HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12 MED-QUEST DIVISION

CHAPTER 1739

AUTHORIZATION, PAYMENT, AND CLAIMS IN THE FEE-FOR-SERVICE MEDICAL ASSISTANCE PROGRAM

Subchapter 1 General Provisions for Reimbursement

Subchapter 2 Long Term Care Prospective Payment System

Subchapter 3 Prospective Payment for Acute Care Services

Historical Note: This chapter is based substantially upon chapter 17-1322. [Eff 11/13/95]

SUBCHAPTER 1

GENERAL PROVISIONS FOR REIMBURSEMENT

§17-1739-1 Purpose. This chapter shall implement the state plan requirements for payments made by the state medicaid agency for the fee-for-service component for services received under the medical assistance program. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: HRS §346-59)

§17-1739-2 Definitions. As used in this chapter:
"Automated tests" means laboratory tests automatically conducted through a mechanical testing aid.

"Clean claim" means one that can be processed without obtaining additional information from the provider of the service from a third party.

"Controlled procedure" means a procedure that is rendered often enough by a provider or group of providers that specific usual or customary charge data for the procedure can be established based on the usual and customary methodology.

"Conversion factor" means the element that is used in calculating reimbursement for non-controlled procedures. The conversion factor is multiplied by the number of units assigned to each procedure. Conversion factors are determined by adding all submitted charges for all procedures within a specialty (with the exception of laboratory services) and dividing by the total number of units for all the submitted procedures. This can be determined for specific providers or specialties.

"Cost-share" means the amount identified by the department as an applicant's or recipient's excess income available for meeting a portion of the individual's own health care cost.

"Coterminous" means the health care provider's contract with medicaid shall be invalid upon termination of the state department of health's certification of the provider's compliance with state and federal requirements.

"Customary charge" means a charge for a particular procedure established at a calculated percent as determined by the legislature of weighted usual charges for a particular procedure from throughout the State within a given specialty (with the exception of

laboratory services). In the absence of sufficient data to develop a customary charge within a specialty, the fiscal agent shall apply the customary charge for a procedure based on charges from all specialties.

"Drug formulary" means a listing of prescribed drug items for which payment may be made by the Hawaii medicaid program.

"Employer" means one who employs another or who contracts with another for services in return for wages or payment.

"Established provider" means one who has been in the medicaid program for twelve months or more.

"Estimated acquisition cost for a drug product" means one of the following which shall be designated by the department:

(1) The average wholesale price minus 10.5 per cent; or

(2) The manufacture direct price.Average wholesale price shall be derived from the most commonly used packaged size listed in the Bluebook or the department's best estimate of the price generally and currently paid by providers for a drug labeler in the package size most frequently purchased by providers.

"Estimated acquisition cost for a medical supply" means the average wholesale price minus 10.5 per cent. Average wholesale price shall be derived from the most commonly used packaged size listed in the bluebook or the department's best estimate of the price generally and currently paid by providers for a product marketed or sold by a particular manufacturer or labeler in the package size most frequently purchased by providers.

"Factor" means an individual or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold, or transferred to the individual or organization for an added fee or a deduction of a portion of the accounts receivable.

"Federal upper limits (FUL)" for a drug product means the price established by the Health Care Financing Administration using various criteria.

"Median charges" means the middle of all the actual charges made for a given service by a provider.

"Medicare carrier" means an individual or organization contracted by the Social Security Administration to administer a portion or all of the locality's Medicare program.

"New provider in town" means a provider who has

been in the medicaid program for less than twelve months. A new man in town, by definition, does not have a previous history of charges to the Hawaii medicaid program and, therefore, no usual charge can be established. A new provider in town is limited to charging up to fifty per cent of weighted usual charges for a given procedure by specialty (with the exception of laboratory services) as specified and adjusted by the legislature.

"Panel test" means a set of two or more laboratory tests done concurrently or in conjunction with the others.

"Part A" means Medicare hospital insurance benefits.

"Part B" means Medicare medical insurance benefits.

"Part B, Medicare" means the elective, supplementary medical insurance portion of Medicare.

"PPS" means the prospective payment system of reimbursement.

"Practitioner" means a licensed doctor of medicine, dentistry, osteopathy, podiatry, and any other individual licensed practitioner of health care services the department chooses to include in its medicaid program.

"Primary physician" means a practitioner selected by the recipient to manage the recipient's utilization of health care services.

"Profile" means a pattern of charges and reimbursements for selected services by any given practitioner, specialty, or profession for a given period of time.

"Program" means the state-administered medical assistance program as authorized under title XIX of the Social Security Act (42 U.S.C. §§1396-1396j) and chapter 346, HRS.

"Provider" means a provider of health care services, equipment, or supplies that is participating in the medicaid program.

"QMB" means Qualified Medicare Beneficiaries.

"Reasonable charge" means an individual charge determination made by the fiscal agent on a covered noninstitutional item or service subject to the medicaid reasonable charge methodology.

"Routine nursing salary cost differential" means the amount reimbursed to a provider for the cost of inpatient routine nursing care for aged patients.

"Seventy-fifth percentile" means the top of the

range of usual charges that is established as the overall limitation of reimbursement for the health care service.

"Spend-down" means the amount identified by the department as available from the recipient's income to meet a portion of the individual's health care cost.

"State maximum allowable cost (MAC)" for a multi-source drug product means the average of the estimated acquisition costs of the three least expensive generics available. At least one of the three generic products shall be provided by a manufacturer who participates in the Federal Drug Rebate Program.

"Usual charge" means the median fee charged by the provider for a specific service during the profile period selected by the legislature. The middle charge or the lowest charge which is high enough to include fifty per cent of all charges for that procedure from the provider shall be selected as that provider's usual charge for that procedure.

"Visiting consultant" is a medicaid provider who has expertise or knowledge in a specific area and generally recognized by the community as a specialist and this expertise or service is not readily available on a particular island. Included as a visiting consultant are specialists who are requested by other providers to render second opinions or to participate in the medical treatment of medicaid recipients.

"Weighted customary charges" means that in calculating the customary charge for a given service, the usual charges made for a service by each provider within a specialty are arrayed in ascending order and weighted by how often a service was rendered at that charge. [Eff 11/13/95; am 01/29/96; am 11/25/96; am 12/27/97] (Auth: 42 U.S.C. §405.1902; HRS §346-14) (Imp: HRS §§346-14, 346-53; 42 U.S.C. 1396R(p))

§17-1739-3 Controlling factors for payment. (a) The department shall pay for the cost of medical care when the department's medical consultants determine medical care to be necessary to the eligible patient's well-being and medical care is provided, under standards generally acceptable to the medical community, by a practitioner approved by the department to participate in medicaid.

(b) The department shall not increase the payment made to any provider to offset uncollected amounts for

deductibles, coinsurance, copayments, or similar charges.

(c) Payments for services shall not exceed reasonable charges consistent with efficiency, economy, and quality of care.

(d) No payment shall be made where program rules are violated, or when services furnished are inappropriate to the patient's health care management as determined by the department's medical consultant.

(e) Rates of payment to providers of medical care who are individual practitioners shall be based upon a fee profile of usual and customary fees selected by the legislature as the basis of the appropriation for the care for any fiscal year.

(f) Rates of payment to out-of-state providers of medical care who are individual practitioners shall be the medicaid rate paid in the practitioner's state, subject to the conditions of section 17-1736-13. In the absence of a medicaid payment rate, the provisions of subsection (e) or (i) shall be applicable.

(g) Payments may be prepaid to health maintenance organizations which the department contracts to provide medical care to eligible public assistance recipients.

(h) The department may withhold payment of claims to recoup overpayments, or may withhold payment pending completion of an audit or investigation.

(1) Payment of pending or future claims may be withheld in an amount reasonably calculated to approximate the amounts of past overpayments.

(2) Payment of pending claims may be withheld until completion of a pending audit or investigation, at which time the department may initiate actions to recoup the amounts of any overpayments discovered.

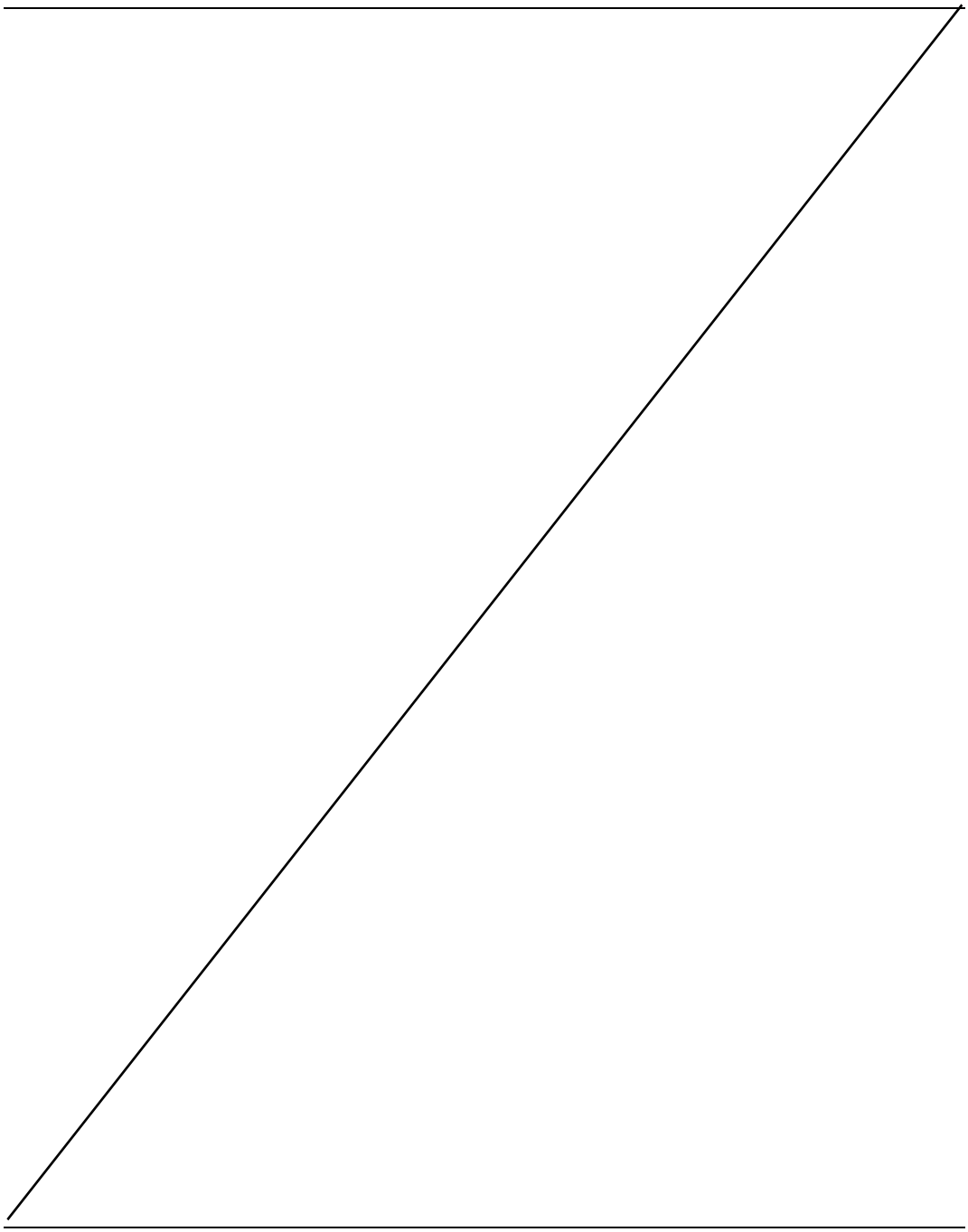
(3) The department shall notify the provider in writing of its intent to withhold payments and shall include reasons for the proposed action, the effective date of the action, and a statement of the provider's right to request administrative review of the proposed action.

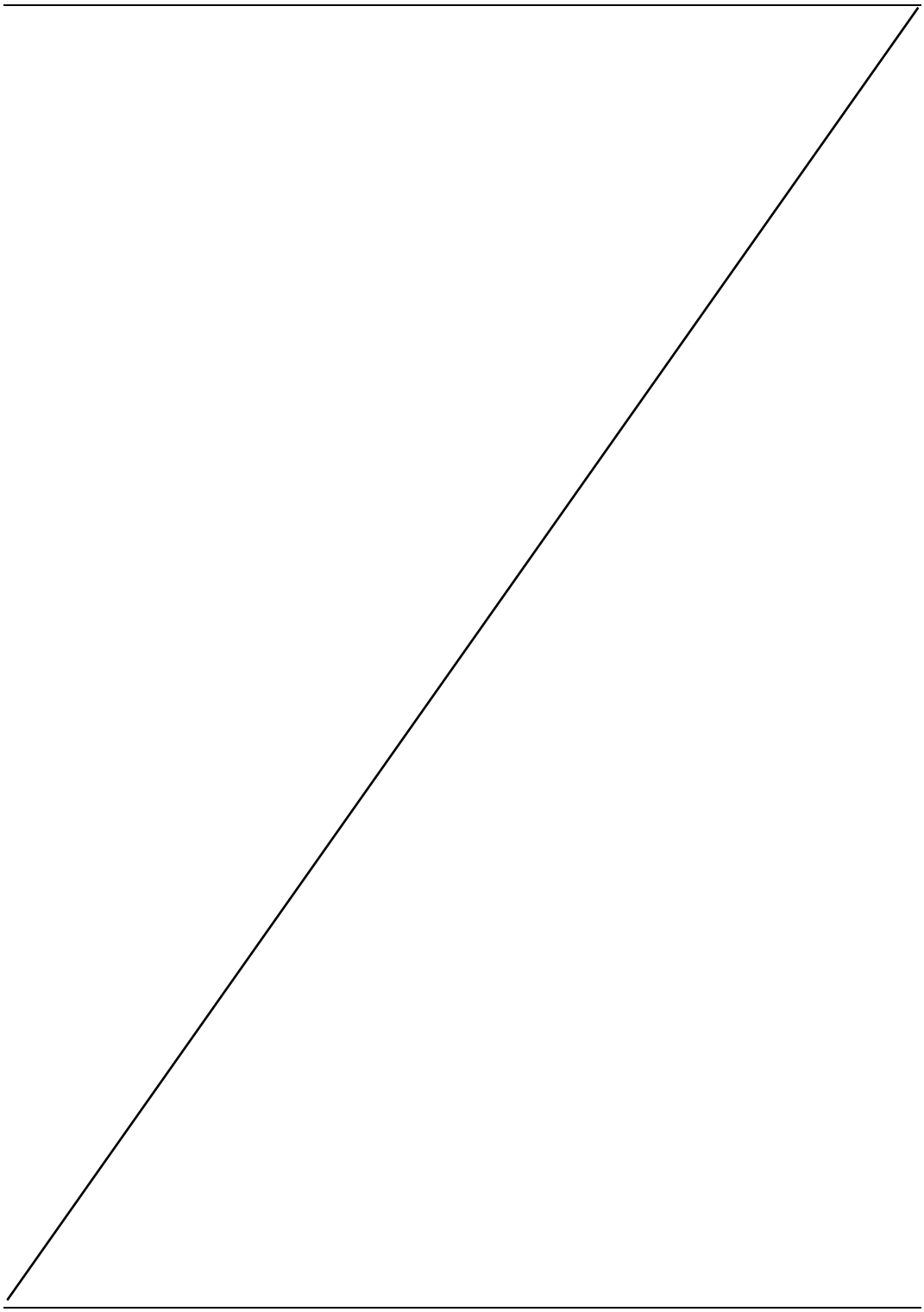
(4) The effective date of withholding shall be sixteen calendar days following the issuance of the notice.

(i) In the absence of data necessary to establish a usual charge, a customary charge, or applicable unit values, and where no Medicare reasonable charge exists,

the claim shall be paid on the basis of rates established by the department.

(j) Payments for QMB recipients are limited to premiums, deductibles, and coinsurance under Part A and





Part B of Medicare. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §§447.57, 447.200; 42 U.S.C. 1396r(p))

§17-1739-4 Authorization of services. (a) The department shall provide:

(1) Methods of administration necessary for the proper operation of the medicaid program; and

(2) Procedures relating to the utilization of and the payment for care and services available under the program. Among the procedures the department may employ shall be a system of authorization of selected types of costly health care.

(b) Authorization shall insure that all services and materials provided are needed, that all adequate, less expensive alternatives are considered, and that services and materials provided conform to currently accepted community standards of the profession involved. The authorization function may be contracted to certain individuals or organizations, including the State's fiscal agent. However, services in the State of Hawaii which necessitate immediate professional medical action shall not be subject to prior authorization if obtaining prior authorization may delay service and place a patient in jeopardy. For all such services, a request for medical authorization, DHS form 1144, must be submitted within five working days after the service date. Authorization may be required when the department considers or has found a service to be associated with, but not necessarily limited to, high or excessive costs provided over extended periods of time without evidence of benefit, or questionable or limited value, or both, or subject to abuse. Authorization is specifically required for the following:

(1) Obtaining special medical services from other United States jurisdictions;

(2) Termination of regulatory controls, for example, release from physicians' management (reference is to recipients assigned to a primary physician);

(3) Psychological tests on an outpatient basis;

(4) Short-term inpatient psychiatric admission;

(5) Purchase or cumulative rental of durable medical equipment and purchase of medical supplies with a cost of more than $50;

(6) Selected drug products as designated by the medical assistance program and drugs not normally encompassed in the department's drug formulary or dosages in excess of permitted levels or for periods in excess of thirty days;
(7) Hearing evaluation and rental or purchase of hearing aids;
(8) Replacement glasses, special glasses, or other visual aids;
(9) Physiotherapy and occupational therapy for outpatients other than ultrasound therapy for musculoskeletal problems;
(10) Lodging, meals, and transportation for recipients for medical purposes, including out-of state and inter-island transportation by scheduled carrier, air ambulance, ground ambulance, handicab, or taxi;
(11) Detoxification;
(12) Group therapy;
(13) Psychiatric outpatient visits;
(14) Certain dental services;
(15) Admission and Medicaid coverage of persons in long-term care facilities and subacute level of care;
(16) Services, lodging, and transportation of medical attendants to accompany a recipient to another island or out-of-state;
(17) All surgical procedures that are performed in the outpatient and inpatient hospital settings by podiatrists and for all surgical procedures costing more than $50 that are performed in the office by podiatrists; and
(18) Home pharmacy services;
(19) Sleep laboratory and sleep disorder center services; and
(20) Other medical services as may be identified by the department.

(c) The department, through its medical consultants, may place appropriate limits on a medicaid service based on such criteria as medical necessity or utilization control procedures. The department shall pay for health care services when the department's medical consultants determine that the services are necessary to the patient's well-being and the services are provided under standards accepted by the medical profession. However, no payment shall be made in situations where program rules were violated or when

services furnished did not involve economical or effective health care management of the patient.

(d) Authorization, when required, may be obtained by submission of an authorization form adequately justifying the service and signed and dated by the attending physician within thirty days before or after the service is rendered. Authorization is required before the service is rendered for those services listed in subsection (b).

(e) When authorization is sought for services which were already rendered, an appropriate report must be submitted including the reason for the untimely submittal.

(f) The department, through its medical consultants, may permit exceptions, and determine level of care services, medical appropriateness, and medical necessity. In a disagreement regarding claims for services and level of care determinations, the medical consultants' decision shall be final. Further appeal shall be pursued through the appeal administrator's office or the courts.

(g) Incomplete authorization forms or a request for additional information from a provider which is not received within the time period specified by the department shall result in a denial of the request.

(h) A request for a DHS consultant's or authorized representative's authorization shall be acted upon within thirty days and a copy of the decision, together with reasons for the decision, if the request is denied, shall be sent to both the provider and the recipient.

(i) Approved authorization requests and treatment plans shall be initiated within sixty days of the signed approval by the department. [Eff 11/13/95; am 01/29/96; am 11/25/96] (Auth: HRS §346-59) (Imp: 42 C.F.R. §§456.1, 456.2, 456.3)

§17-1739-5 Methods of payment. (a) State payments for medical services shall not be provided to anyone except the:

(1) Provider; or

(2) Recipient for settlement of a legal suit or fair hearing.

(b) Payment to an individual shall be prohibited, except in specified circumstances where payment is reassigned to another person, facility, or organization by the provider. The circumstances include payment made:

(1) In accordance with a reassignment from the provider to a government agency or reassignment by a court order;
(2) To a business agent, such as a billing service or an accounting firm, that furnishes statements and receives payments in the name of the provider. The agent's compensation for the service shall be related to the cost of processing the billing, and not on a percentage or other basis of the amount that is billed or collected, and the compensation shall not be dependent upon the collection of the payment; and
(3) To the following:
(A) The employer of the practitioner, if the practitioner is required as a condition of employment to turn over the fees to the employer;
(B) The facility in which the service is provided, if the practitioner has a contract under which the facility submits the claim; or
(C) A foundation, plan, or similar organization operating an organized health care delivery system, if the practitioner has a contract under which the organization submits the claim.

(c) Payment for any service furnished to a recipient by a provider shall not be made to or through a factor, either directly or by power of attorney.

(d) Participation in the State's medicaid program shall be limited to providers who accept, as payment in full, the amounts paid by medicaid with the exception of amounts specifically identified as the recipient's spend-down or cost-share. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.1; 42 U.S.C. §§1902 (a)(4) and (a)(32))

§17-1739-6 Medicaid payments to individual practitioners. (a) The medicaid reasonable charge shall be the lowest of:
(1) The actual charge of the provider;
(2) The provider's usual charge for that service as specified and adjusted by the legislature;
(3) The customary charge for that service as specified and adjusted by the legislature;
(4) The provider's Medicare reasonable charge

(including the economic index and the lowest charge level) for that service for the base year selected by the legislature; or

(5) The maximum amount allowed by federal law and regulation.

(b) Items and services subject to the medicaid reasonable charge shall be as follows:

(1) Laboratory services (charges from all specialties from throughout the State are included in establishing the customary charge or conversion factor, as appropriate);
(2) X-ray services;
(3) EPSDT services;
(4) Family planning services;
(5) Physician services;
(6) Podiatric services;
(7) Optometric services;
(8) Other practitioner services;
(9) Physician based clinics;
(10) Dental Services (including dentures);
(11) Physical therapy;
(12) Occupational therapy;
(13) Services for persons with speech, language, and hearing disorders (exception: There shall be a flat rate for hearing evaluations.); and
(14) Other services specified by the department.

(c) Providers who are visiting consultants to the neighbor islands may be reimbursed travel charges on the condition that an addendum to their provider agreement is submitted with the following information for approval by the department:

(1) The neighbor island to be visited;
(2) Frequency of visits; and
(3) Location where individuals are to be seen.

(d) Reimbursements may be made to providers who are visiting consultants as follows:

(1) $8 per patient visit; and
(2) An additional $7 per patient visit if hospital charges for supplies and equipment are assessed to the visiting consultant. Justification shall be required on the individual claim form when requesting this additional fee.

(e) Payments made for QMB recipients shall be limited to deductibles and coinsurance under Part A and Part B of Medicare. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §§405.502, 405.503; 42 U.S.C. 1396r(p))

§17-1739-7 Payments to individual practitioners providing therapy services in long-term care facilities. (a) Payment for physical and occupational therapy, and speech, language, and hearing disorder services provided to a medicaid recipient in a long-term care facility shall be the lesser of the usual charges to the general public or the maximum payment schedule published by the department.

(b) Payment shall be made for only those covered therapy services specified in sections 17-1737-79, which are determined to be medically necessary, prescribed by a physician, and provided by a licensed or certified therapist approved by the medicaid program.

(c) Payment shall be made only upon submission of a Hawaii claim form (UB-82 or DHS-1500), by a provider eligible to bill for the services under the Medicare and medicaid programs. Facilities with Medicare numbers shall use the form UB-82. Individual therapists shall use the form DHS-1500.

(d) In the case of speech evaluation and training, and hearing evaluation and hearing aids, an authorization form (DHS 1144), shall be attached to the claim form.

(e) In the case of persons eligible for both Medicare and medicaid who reside in an intermediate care facility, payment shall be made only if Medicare payment has been sought and denied.

[Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-8 Medicaid payments for other noninstitutional items and services. (a) The following services shall be limited to billed charges not to exceed Medicare's upper limit of payment:

(1) Durable medical equipment;
(2) Hearing aids;
(3) Home health agency services; and
(4) Prosthetic devices and appliances except that intraocular lens implants are governed by the Medicare reasonable charge unless documentation is provided that actual costs are higher.

(b) Payments for outpatient hospital services shall not exceed the lowest of the rate negotiated by the department, seventy-five per cent of billed charges, or Medicare's upper limit of payment.

(c) Payments for an emergency room shall not exceed the lowest of the rate negotiated by the department, seventy-five per cent of billed charges, or Medicare's upper limit of payment.

(d) Payments for frames for eyeglasses shall be limited to a flat rate set by the department based on a study of industry prices.

(e) Payments for lenses for eyeglasses shall be limited to billed charges, however billed charges shall not exceed cost plus ten per cent.

(f) Payments for hearing devices shall be the actual claim charge or $300, whichever is lower. Exceptions may be made for special models or modifications.

(g) Payments for nurse midwife services shall be limited to seventy-five per cent of the sponsoring physician's Medicaid reimbursement rate.

(h) Payments to pediatric nurse practitioners and family nurse practitioners shall be limited to seventy-five per cent of the prevailing customary Medicaid allowance for pediatric physicians and family practice physicians.

(i) Payments for clinic services (other than physician-based clinics) shall be limited to rates negotiated by the department. The types of clinics include government sponsored non-profit, and hospital-based clinics.

(j) Payments for teaching physicians shall be limited to rates negotiated by the department and shall be paid to the teaching fund, not to the physician.

(k) Payment for prescribed drugs shall be made as described in section 17-1739-11.

(l) The Hawaii Medicaid program shall not pay more than the billed amount for any noninstitutional item or service or more than the amount permitted by federal law or regulation.

(m) Payment for medical supplies shall be the lowest of the rate set by the department, the estimated acquisition cost (EAC), or Medicare's upper limit of payment.

(n) Payments for home pharmacy services shall be the lower of the rate set by the department or Medicare's upper limit of payment.

(o) Payments for sleep services shall be the lower of the rate set by the department or Medicare's upper limit of payment.

(p) Payments to a facility for non-emergency care rendered in an emergency room shall not exceed the

lowest of:
(1) The rate negotiated by the department;
(2) Seventy-five per cent of billed charges; or
(3) Medicare's upper limit of payment.
The payment to an emergency room physician for the screening and assessment of a patient who receives non-emergency care in the emergency room shall not exceed the payment for a problem focused history, examination, and straightforward medical decision making.

(q) The upper limits on payments for all noninstitutional items and services shall be established by the department in accordance with section 346-59, HRS, and other applicable state statutes. [Eff 11/13/95; am 01/29/96; am 11/25/96; am] (Auth: HRS §346-59) (Imp: 42 C.F.R. §§447.201, 447.304)

§17-1739-9 Payments for intra-state transportation and related services. (a) Payments for ground ambulance and air ambulance services shall be limited to the lowest of billed charges, rate negotiated by the department, and the Medicare allowance.

(b) Except for a recipient who is a stretcher patient, payment for air transportation shall not exceed the inter-island air fare charged the other persons on the recipient's flight, or a contracted amount previously agreed upon between the airlines and the department for emergency chartered flights, whichever is lower. For transportation of a stretcher patient by the scheduled inter-island carrier, payment shall not exceed the air fare charged for four seats on the recipient's flight.

(c) A round trip air fare shall be paid for an attendant whose services are recommended by the attending physician or are required by the airline. Prior approval of the department's medical consultant is necessary, except in emergency situations, when the attending physician's authorization is sufficient, subject to the department's medical consultant's review. In addition, payment shall be made for the attendant's service, provided the attendant is unrelated to the patient. The amount of payment for the attendant's service shall not exceed the following applicable rates:

(1) Attendant leaves island and returns same day ..... $20.

(2) Attendant is required to stay overnight on another island..... $40.

(d) Payments for emergency air ambulance services shall be based upon prearranged contracted rates between the air carrier and the department, not to exceed the rates charged the general public or the amounts paid by Medicare, whichever is lower. The emergency trip shall be authorized by the attending physician using the form designated by the department.

(e) Payments for emergency ground ambulance services shall be based upon prearranged contracted rates between the provider and the department, not to exceed rates charged the general public or the amounts paid by Medicare, whichever is lower. Additional amounts shall be paid for lifesaving measures administered in the ambulance such as the use of oxygen. The charge shall not exceed the provider's customary charge to the general public, the rate set by the department, or Medicare's reimbursement level for the same service. Recipients requiring ambulance service shall have the emergency trip authorized by the attending physician using the form designated by the department or by the medical consultant of the department.

(f) Payments for non-emergency air and ground ambulance services using advanced life support (ALS) air and ground ambulances shall be at the rate set by the department, not to exceed the rate charged to the general public or the Medicare allowance.

(g) Payments for medical taxi services shall be by purchase order issued by the branch office and only on trips to or from a physician's office, clinic, hospital, or airport (for covered medical transportation) and the patient's home. Reimbursement for those services shall be further limited as follows:

(1) No detours or side trips shall be permitted;

(2) The amount of payment shall be made on the basis of metered rates charged the public; and

(3) Payments shall not include compensation for the driver's waiting time at the clinic, hospital, physician's office, or at the location of other providers of medical services.

(h) Lodging and meals for Medicaid patients or attendants authorized by the attending physician, in an emergency situation, or the department's medical consultant shall be paid through purchase orders to the providers issued by the branch unit.

(i) Payments for non-emergency transportation (e.g. handicabs, but not taxis), shall be limited to rates established by the department. [Eff 11/13/95; am 01/29/96] (Auth: HRS §346-59) (Imp: 42 C.F.R. §§447.201, 447.304)

§17-1739-10 Payments for out-of-state transportation and related services. (a) Payments shall be made for out-of-state transportation, meals and lodging when these services are authorized in accordance with section 17-1739-9.

(b) Out-of-state air transportation shall be paid by a purchase order made out to the airlines or travel agency.

(c) Ground transportation expenses, subject to subsection 17-1739-9(f), shall be allowed when these expenses are incurred by the recipient. Verification of ground transportation expenses shall be documented completely on the proper departmental form when reimbursement is requested.

(d) Payment for meals and lodging shall be the lesser of the per diem rate of $100 a day or the actual charge for lodging plus a daily per diem of $30 for meals.

(e) The $30 per diem shall be prorated equally for three meals and shall begin with the first meal upon arrival at the specified destination and ending with the last meal prior to flight departure home. [Eff 11/13/95] (Auth: HRS §346-59; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §§447.201, 447.304)

§17-1739-11 Payment for drugs and related supplies. (a) The state medical assistance program shall determine allowances for prescribed drugs using the following criteria:

(1) Single source drugs shall not exceed the lower of:
    (A) The billed charge;
    (B) The provider's usual and customary charge to the general public; or
    (C) The estimated acquisition cost (EAC) for a drug product plus a reasonable dispensing fee;
(2) Multiple source drugs shall not exceed the lower of:
    (A) The billed charge;

(B) The provider's usual and customary charge to the general public;
(C) The estimated acquisition cost (EAC) for a drug product plus a reasonable dispensing fee;
(D) The federal upper limit (FUL) price plus a reasonable dispensing fee; or
(E) If no federal upper limit, the state maximum allowable cost (MAC) plus a reasonable dispensing fee.

(3) Over-the-counter (OTC) drugs shall not exceed the lower of:
(A) The billed charge;
(B) The provider's usual and customary charge to the general public including any sale price which may be available on the day of service;
(C) The allowance set by the program (state maximum allowable cost);
(D) The estimated acquisition cost (EAC) for a drug product plus a reasonable dispensing fee; or
(E) The federal upper limit (FUL) price plus a reasonable dispensing fee;
Under no circumstances shall the program pay more than the general public for the same prescription or item;

(4) Payments for medical supplies shall be the lower of:
(A) The rate set by the department;
(B) The estimated acquisition cost (EAC) for a medical supply plus a reasonable dispensing fee; or
(C) Medicare's upper limit of payment;

(5) The state medical assistance program requires that the lower cost equivalent drug product be dispensed if available in the marketplace and substitution is not prohibited by part VI, drug product selection of chapter 328, HRS. The recipient may refuse lower cost drug products but must pay the entire cost of the higher price equivalent;

(6) The federal upper limit price or the state maximum allowable cost shall not apply if the practitioner:
(A) Certifies in his or her own handwriting that a specific brand is medically necessary for a particular recipient. A checkoff box is not acceptable but a

notation of "brand medically necessary" or "do not substitute" is allowable;

(B) Obtains medical authorization for medical necessity from the state medical assistance program for specific brands of medications designated by the program. In such cases, the payment shall not exceed the lower of:

(i) The billed charge;

(ii) The provider's usual and customary charge to the general public; or

(iii) The estimated acquisition cost for a drug product plus a reasonable dispensing fee;

(7) Reimbursement for over-the-counter drugs shall be limited to the over-the-counter drug prescribed by the licensed practitioner and specifically designated by the medical assistance program. Over-the-counter drugs not specifically designated shall require medical authorization for medical necessity by the medical assistance program;

(8) The state Medicaid agency shall set the dispensing fee by taking into account the results of surveys of the cost of pharmacy operations. The agency must periodically survey pharmacy operations; and

(9) Payment for prescribed drugs dispensed to outpatients and patients of long-term care facilities shall be made only upon the submission of an itemized claim by the dispensing provider (Form 204, hardcopy or electronic media claim (EMC) or via point-of-sale (POS).

(A) The dispensing fee for any maintenance or chronic medication shall be extended only once per thirty days without medical authorization from the medical assistance program. Other appropriate limits regarding the number of dispensing fees paid per interval of time shall be determined as necessary by the medical assistance program;

(B) Consultation services of pharmacists in long-term care facilities (i.e., chart reviews, utilization review meetings, inventory reviews, etc.) shall be reimbursed up to a monthly maximum of

$75 plus $3 times the facility's present total beds;

(C) Emergency calls by the pharmacist to the long-term care facility shall be paid up to a maximum of four calls for each one hundred beds in the facility at the time services are rendered, at $25 an emergency call. Any fraction of one hundred shall be prorated accordingly; and

(D) Facilities with less than twenty-five beds at the time services are rendered may charge up to one full emergency call per month. An emergency call shall be one that cannot be delayed, i.e. non-routine call to the patient of a facility by the pharmacist in a life-threatening situation. All other services shall be handled during the pharmacist's routine visits whenever possible.

(b) The following conditions shall apply to payment for drugs dispensed by physicians and dentists from the physicians' and dentists' offices:

(1) Physicians and dentists dispensing medications from the physicians' and dentists' offices shall be reimbursed at the estimated acquisition cost plus 50 cents; and

(2) If there is no pharmacy within five miles of the provider's office, special consideration for payment at the pharmacy rate may be made upon written request to the department's med-QUEST administrator for approval.

[Eff 11/13/95; am 01/29/96; am 11/25/96; am 12/27/97, am 09/14/98] (Auth: HRS §346-59) (Imp: 42 C.F.R. §§447.331, 447.332, 447.333)

§17-1739-12 Advisory estimated acquisition cost committee. (a) An advisory estimated acquisition cost committee shall be appointed by the director of the department, and shall consist of:

(1) One of the department's medical consultants;

(2) The department's pharmacy consultant who shall serve as chairperson;

(3) One practicing physician from the community;

(4) Three practicing pharmacists;

(5) Two members from either the pharmaceutical wholesale or manufacturing industry; and
(6) One lay person.

(b) The term of each committee member shall be two years and overlapped in such a way that expiration of terms do not cause a total membership change.

(c) A quorum shall consist of a simple majority of the total number of members.

(d) The duties of the advisory estimated acquisition cost committee shall be to:
(1) Meet semi-annually or when called by the chairperson;
(2) Review available data and advise the department of maximum estimated acquisition costs that should be paid for specific drug products that:
(A) Are available from multiple sources;
(B) Represent significant program expenditures;
(C) Could result in significant program savings; and
(D) Are considered to be bioequivalent by the food and drug administration.

(e) Actions of the advisory estimated acquisition cost committee shall be:
(1) Subject to the approval of the medical care administrator;
(2) Circulated to appropriate providers; and
(3) Effective upon receipt by providers unless otherwise stated. [Eff 11/13/95] (Auth: HRS §346-14) (Imp: 42 C.F.R. §447.332)

§17-1739-13 Drug use review (DUR) board. (a) An advisory drug use review board shall be appointed by the director of the department, and shall consist of:
(1) The department's pharmacy consultant or medical consultant or both, shall serve as the drug use review coordinator(s);
(2) Four persons licensed and actively engaged in the practice of medicine in the state;
(3) Four persons licensed and actively practicing pharmacy in the state; and
(4) One person actively practicing as a medical service representative in the state.

(b) The term of each drug use review board member shall be three years and overlapped in such a way that

expiration of terms shall not cause a total membership change.

(c) A quorum shall consist of five board members; at least one of the five must be a physician or pharmacist.

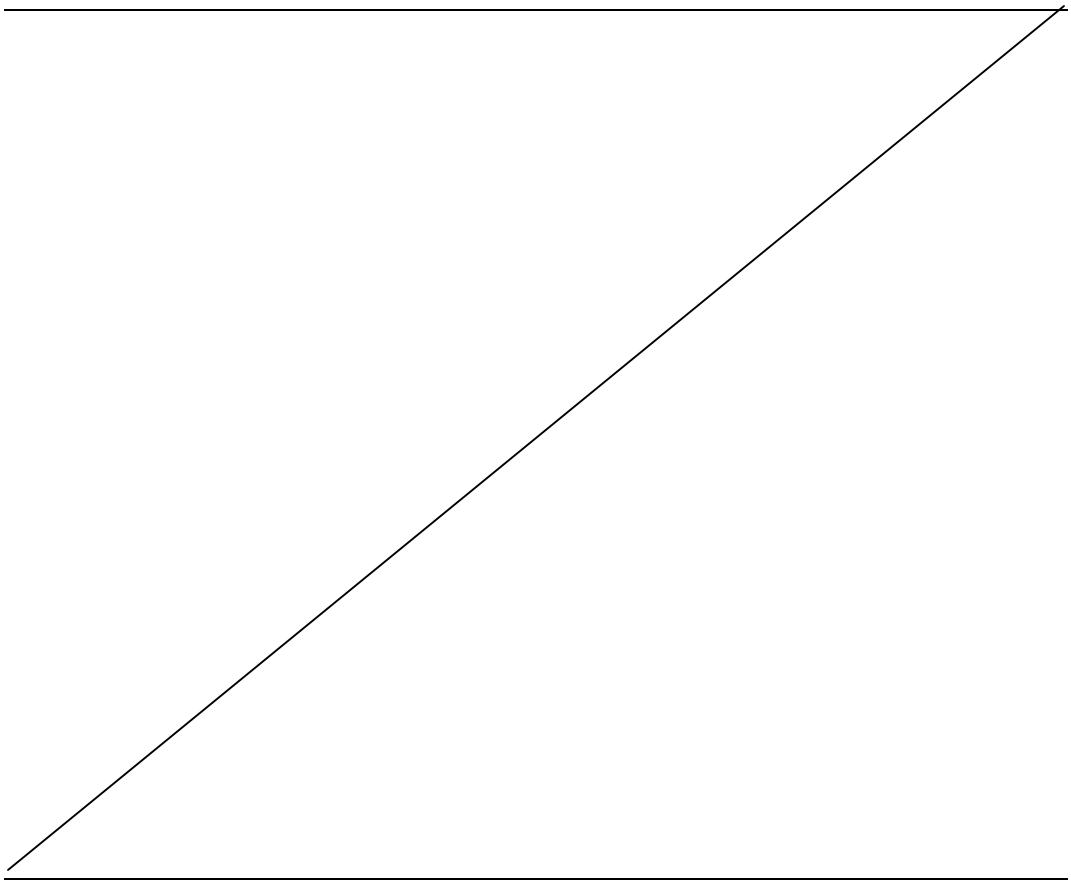
(d) The duties of the advisory drug use review board shall be to:

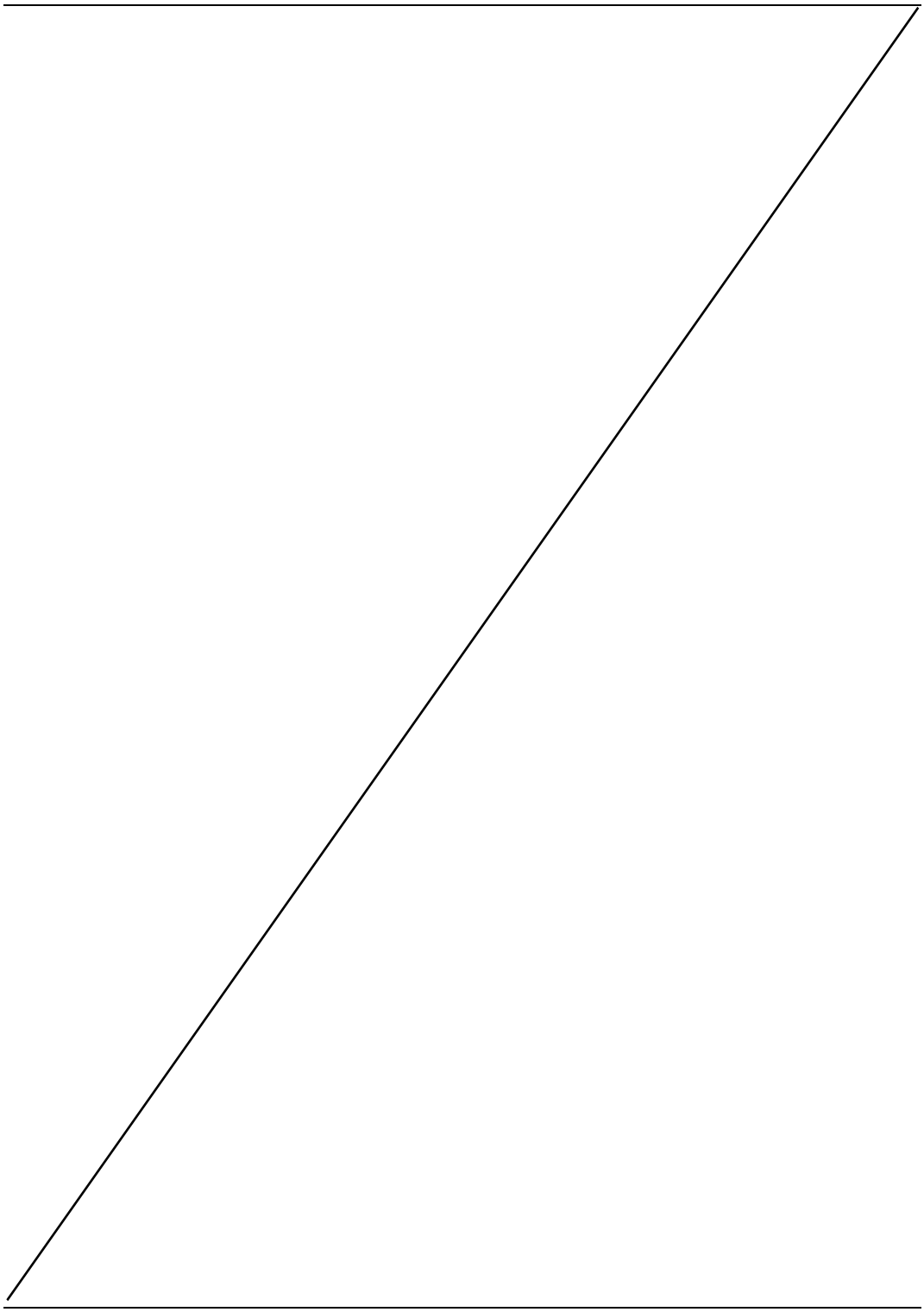
(1) Meet when called by the chairperson;

(2) Develop, review, and adapt criteria and standards for prospective and retrospective drug use review;

(3) Make policy recommendations to the Hawaii Medical assistance program in respect to confidentiality of patient related data, and all aspects of the drug use review program;

(4) Decide on and monitor educational programs and interventions deemed appropriate based on potential therapeutic problems identified through the program; and





(5) Determine the content and mix of educational programs and interventions for practitioners, designed to enhance the clinical appropriateness and cost effective use of prescription drugs with primary emphasis on therapeutic outcomes and quality of care.

(e) The actions of the drug use review board shall be:

(1) Subject to the approval of the department;

(2) Remain confidential within the department; and

(3) Be communicated to the specific providers affected. [Eff 11/13/95] (Auth: HRS §346-14; P.L. 101-508) (Imp: 42 C.F.R. 456)

§17-1739-14 Medical payment involving third party liability. (a) The liability of a third party for the cost of the medical services shall be treated as a resource applicable to the cost of needed medical services when:

(1) It has been verified that a legal obligation actually exists; and

(2) The amount of the obligation may be determined within thirty days from the time of the recipient's need for medical care.

(b) No medicaid payment may be made under a refund plan for that portion of cost for which a third party has been determined to be liable and reimbursement is forthcoming. An exception is medicaid's agreement with Medicare on durable medical equipment processing.

(c) When the existence or extent of third party liability is in question, medicaid payments may be made:

(1) In part, if the recipient has excess income and other assets; or

(2) For the entire cost of the medical services, if the recipient assigns to the department in writing, the third party payment; provided that where third party policy prohibits assignment of payment, the recipient shall, in writing, agree to refund the department upon being paid by the third party. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 45 Fed. Reg. 8984 §§433.135 through 433.154)

§17-1739-15 Time limit for claim submittal and timely claims payment. (a) The provider shall submit claims for payment within twelve months from providing care or services. No medicaid payment shall be made for any claim submitted after this period. For cases involving retroactive assistance, the twelve month period for claim submittal shall start from the date application for medicaid was approved. This subsection shall not apply to payment of deductibles and coinsurance for cases that are eligible for both Medicare and medicaid in which the circumstances leading to a submittal of claim after twelve months are acceptable to Medicare's fiscal agent or carrier.

(b) The department shall pay ninety per cent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within thirty days, and ninety-nine per cent of the clean claims within ninety days of the date of receipt.

(c) The department shall pay all other claims within twelve months of the date of receipt, except where:

(1) Retroactive adjustments are paid to providers who are reimbursed under a retrospective payment system;

(2) A claim for payment under Medicare has been filed in a timely manner and disposed of and the department may pay a medicaid claim relating to the same services within six months of receiving notice;

(3) Claims are from providers under investigation for fraud or abuse; or

(4) Payments are made in accordance with a court order, hearing decision, corrective action, or to extend benefits of these actions to others in the same situation as those directly affected.

(d) The requirements for timely processing of claims can be waived by the department of human services if there are indications of good faith in meeting the requirements. The request for a waiver shall contain a written plan of correction.

(e) Prepayment and post-payment claims review shall be conducted for all claims to verify:

(1) Eligibility and proper authorization of service;

(2) The number of visits and services for consistency with age, sex, and illness;

(3) That payment does not exceed reimbursement rates or limits; and

(4) Third party liability, if any.

(f) In cases where the provider disputes the department's allowance, a request for reconsideration of the payment amount must be submitted to the med-QUEST administrator within one year after the original payment was made.

(g) Post-payment claims review shall meet the requirements dealing with fraud and utilization control.

(h) The department shall provide any reports and documentation in compliance with this chapter and any conditions that the federal Health Care Financing Administration may require. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.45)

§17-1739-16 to §17-1739-20 (Reserved)

SUBCHAPTER 2

LONG TERM CARE PROSPECTIVE PAYMENT SYSTEM

§17-1739-21 Definitions. As used in this subchapter, the following terms shall have the indicated meanings:

"Acuity level A" means that the department has applied its standards of medical necessity and determined that the resident requires a level of medical care from a nursing facility relatively lower than acuity level C. Prior to October 1, 1990, that level of care was appropriately obtained from an ICF. "Acuity level B" means that the department has applied its standards of medical necessity and determined that the resident requires the level of medical care and special services that are appropriately obtained from an ICF/MR.

"Acuity level C" means that the department has applied its standards of medical necessity and determined that the resident requires a level of medical care from a nursing facility relatively higher than acuity level A. Prior to October 1, 1990, that level of care was appropriately obtained from an SNF.

"Acuity ratio" means the estimated average level A direct nursing costs divided by the estimated average

level C direct nursing costs, as determined by the department. For the FY 94 rebasing, the department has determined the ratio to be 1.00:0.8012. Prior to the next rebasing, the department, with the cooperation and assistance of the providers, shall conduct a case mix study to determine whether the Acuity Ratio should be modified.

"Adjusted (Prospective Payment System) PPS rate" means the basic PPS rate and any adjustments to that rate that are applicable to a particular provider. A formula to determine the adjusted PPS rate is defined in Section 17-1739-37.

"Ancillaries payment" means a per diem payment outside of the basic PPS rate to reimburse certain providers for ancillary services that they provide to residents. The payment is available only to selected providers that are incapable of billing medicaid on an itemized fee for services basis at this time. The payment is not an adjustment to the basic PPS rate.

"Audit adjustment factor" means a reduction to the costs reported in a cost report that has not been finally settled by the department to reflect the average amount of costs that the department has historically disallowed for facilities statewide as part of the final settlement process.

"Basic PPS rate" means the sum of the applicable per diem amounts for the direct nursing, capital, and general and administrative components for each provider and for each level of care that the provider is certified to provide, as calculated pursuant to the methodology defined in this plan. It does not include the various adjustments or increases to that basic per diem rate defined in this plan.

"Base year" means that state fiscal year chosen to identify the provider-specific cost reports that are used to calculate the basic PPS rate.

"Base year cost report" means the cost report of a provider that covers the reporting period that ends during the base year.

"Capital component reduction factor" means a fraction with the capital cost per diem projected by a new provider to obtain its initial PPS rates as the numerator and the total projected capital, direct nursing and G&A per diem costs as the denominator.

"Capital incentive adjustment" means an increase to a provider's basic PPS rate that is calculated as follows:

(1) If the capital per diem cost component of the

provider's basic PPS rate is in the lowest quartile of its peer group, then the incentive payment shall be thirty-five percent of the difference between the median per diem for the peer group and the provider's capital per diem cost component;

(2) If the capital per diem cost component of the provider's basic PPS rate is in the second lowest quartile of its peer group, then the incentive payment shall be twenty-five percent of the difference between the median per diem for the peer group and the provider's capital per diem cost component;

(3) Notwithstanding the foregoing, the capital incentive adjustment shall not increase a provider's capital cost component above the capital component ceiling for the applicable acuity level in the provider's peer group.

"Department" means the Department of Human Services of the State of Hawaii, which is the single state agency responsible for administering the medical assistance program.

"FY 94 rebasing" means the rebasing that used the cost reports for fiscal years that ended during the state fiscal year ending June 30, 1992. The basic PPS rates that resulted from the FY 94 rebasing are effective July 1, 1993.

"G&A" means general and administrative.

"G&A incentive adjustment" means an increase to a provider's basic PPS rates that is calculated as follows:

(1) If the G&A per diem cost component of the provider's basic PPS rate is in the lowest quartile of its peer group, then the incentive payment shall be thirty-five percent of the difference between the median per diem for the peer group and the provider's G&A per diem cost component;

(2) If the G&A per diem cost component of the provider's basic PPS rate is in the second lowest quartile of its peer group, then the incentive payment shall be twenty-five percent of the difference between the median per diem for the peer group and the provider's G&A per diem cost component;

(3) Notwithstanding the foregoing, the G&A incentive adjustment shall not increase a provider's G&A cost component above the G&A

component ceiling for the applicable acuity level in the provider's peer group.

"GET adjustment" means the adjustment to the basic PPS rate of a proprietary provider to reimburse it for gross excise taxes paid to the State of Hawaii. The GET adjustment shall be 1.04167; provided, however, that if the gross excise tax rate is increased or decreased, then the GET adjustment shall be revised accordingly.

"Grandfathered capital component" means the capital component of the basic PPS rates that a new provider or a provider with new beds was receiving immediately prior to the FY 94 rebasing.

"Grandfathered direct nursing and G&A adjustment" means an increase to an eligible provider's basic PPS rates calculated as follows: first, the department shall determine the provider's combined direct nursing and G&A components (including all incentives) as calculated in the FY 94 rebasing; second, the department shall determine the combined direct nursing and G&A component in the total PPS rates that the provider was receiving prior to the FY 94 rebasing for its old beds; third, the department shall increase that second amount by one-half of the inflation adjustment for FY 94; and finally, if the difference between the second amount and the first amount is a positive number, that number shall be multiplied by a ratio of the provider's old beds to its total beds. The product shall be the per diem increase to the provider's basic PPS rates.

"Grandfathered PPS rate" means the total PPS rate that a provider was receiving prior to the FY 94 rebasing.

"Hurricane Iniki adjustment" means an adjustment to the rates of freestanding providers on the Island of Kauai so that the provider receives the higher basic PPS rate calculated under the following two options:

(1) Basic PPS rates based on the provider's costs as calculated pursuant to sections 17-1739-26, 17-1739-27, 17-1739-28 and 17-1739-29 of this rule and adjusted pursuant to all other applicable provisions of this rule (including the addition of new beds since the base year as described in sections 17-1739-30, 17-1739-31, and 17-1739-32);

(2) The PPS rate that the provider was receiving prior to the FY 94 rebasing plus the

inflation adjustment for each subsequent year;

(3) The Hurricane Iniki adjustment shall apply only to the state fiscal years ending June 30, 1994 and June 30, 1995.

"ICF" means intermediate care facility.

"ICF/MR" means intermediate care facility for the mentally retarded. The term also refers to a level of certification of a provider by medicaid.

"Inflation adjustment" means the estimate of inflation in the costs of providing Nursing Facility services for a particular period as estimated in the DRI McGraw-Hill Health Care Costs: National Forecast Tables, HCFA Nursing Home Without Capital Market Basket, or its successor.

"Insufficient experience" means that a provider's base year cost report indicates that the provider delivered less than one hundred days of care at a particular acuity level in the base year.

"Level A rate" means the PPS rate for care delivered by a provider to an acuity level A resident in a nursing facility.

"Level B rate" means the PPS rate for care delivered by a provider to an acuity level B resident in an intermediate care facility for the mentally retarded.

"Level C rate" means the PPS rate for care delivered by a provider to an acuity level C resident in a nursing facility.

"Maintenance therapy" means therapy provided by nursing staff or others whose purpose is not restorative or rehabilitative, but rather to prevent the decline in the physical capabilities of patients. Maintenance therapy does not include physical therapy services that are reimbursed outside of the basic PPS rates.

"Medicaid" means the program to provide certain medical services to eligible individuals as defined generally in Title XIX of the Social Security Act, as amended from time to time.

"New beds" means beds of providers that were placed into service after the implementation of the Hawaii medicaid program's initial prospective payment system.

"New provider" means a provider that began operations after the implementation of the Hawaii medicaid program's initial prospective payment system.

"NF tax adjustment" means the adjustment to the

basic PPS rate to a provider to reimburse it medicaid's share of the taxes paid under Act 315, Hawaii Laws of 1993, as computed and paid according to this plan. The NF tax adjustment shall be 1.06; provided, however, that if the NF tax rate is increased or decreased, then the NF tax adjustment shall be revised accordingly.

"Nursing facility" or "NF" means a provider that is certified as a nursing facility under medicaid.

"OBRA addendum" means the supplement to the cost report, previously prepared by providers to identify the recurring and non-recurring incremental costs of complying with OBRA 87. The OBRA 87 Addendum is no longer required for cost reporting periods beginning on or after July 1, 1993.

"OBRA 87" means the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, and its interpretive guidelines and implementing regulations.

"OBRA 87 adjustment" means the adjustment to the basic PPS rate to reimburse a provider for the incremental costs of complying with OBRA 87, as computed and paid according to this plan.

"Old beds" means the beds of a provider that were placed in service prior to the implementation of the Hawaii medicaid program's initial prospective payment system.

"Patient" means an individual who receives medical care from a provider, and includes both residents and persons whose care is paid for by sources other than medicaid.

"Plan" means this rule, which defines the methods and standards whereby the Hawaii medicaid program sets the rates that it pays to providers for services that they provide to residents.

"PPS" means the prospective payment system defined in this plan.

"Provider" means a facility that is or becomes certified as qualified and contracts with the department to provide institutional long-term care services to residents.

"Rebasing" means calculating the basic PPS rates by reference to a new base year and new base year cost reports. "Rebased" basic PPS rates are the end product of a rebasing.

"Resident" means the individual who is eligible for benefits under medicaid and receives long-term care benefits from or through a provider.

"ROE adjustment" means the adjustment to the basic PPS rate to a proprietary provider to reimburse it for

return on equity, as computed and paid according to this plan.

"SNF" means skilled nursing facility.

"Subacute level" means that the department has applied its standards of medical necessity and determined that the resident requires a level of medical care from an inpatient hospital or nursing facility relatively higher than the acuity level C.

"Subacute level rate" means the PPS rate for care for Group I and the PPS rate for care for Group II delivered by a provider to a recipient who requires the subacute level of care.

"Substitute direct nursing component" means adjusting the direct nursing care component used to obtain a basic PPS rate for an acuity level as follows:

(1) Increasing the facility-specific level A direct nursing component by dividing that component by the acuity ratio; or

(2) Decreasing the facility-specific level C direct nursing component by multiplying its times the acuity ratio;

(3) In calculating the substitute direct nursing component, the acuity ratio shall be applied to the provider's direct nursing component prior to the application of the direct nursing component ceiling.

"Total PPS rate" means the basic PPS rate plus all applicable adjustments, additions or increases to that rate that are defined and authorized in this plan. The total PPS rate for a provider prior to the FY 94 rebasing, however, shall not include the retrospectively settled reimbursement of costs identified in the OBRA 87 addendum.

"Upper limit" means the limit on aggregate payments to providers imposed by 42 C.F.R. §447.272. [Eff 11/13/95; am 11/25/96] (Auth: HRS §346-59; 42 U.S.C. §1396a) (Imp: 42 C.F.R. §447.252)

§17-1739-22 General provisions - purpose and objective. (a) The purpose of this plan is to establish a prospective payment reimbursement system for long-term care facilities that complies with the Social Security Act and the Code of Federal Regulations. The plan describes principles to be followed by providers in making financial reports and describes procedures to be followed by the department

in setting rates, making adjustments to those rates, and auditing cost reports.

(b) Pursuant to the requirements of the Omnibus Budget Reconciliation Act of 1980, the object of this plan is to establish rates for long-term care facilities that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. [Eff 11/13/96] (Auth: HRS §346-59; 42 U.S.C. §1396a(13)(A)) (Imp: 42 C.F.R. §447.250(a))

§17-1739-23 Reimbursement principles. (a) Except as noted herein, the Hawaii medical assistance program shall reimburse providers based on the number of days of care that the provider delivers to the resident, the acuity level that is medically necessary for each day of care, and the provider's PPS rate. The provider shall receive payment at the level A rate for residents who require care at acuity level A, at the level B rate for residents who require care at acuity level B, at the level C rate for residents who require care at acuity level C, and at subacute level rate for residents who require care at the subacute level. Any payments made by residents or other third parties on behalf of residents shall be deducted from the reimbursement paid to providers.

(b) Except as noted herein, the medicaid program shall pay for institutional long-term care services through the use of a facility-specific prospective per diem rate.

(c) The basic PPS rate shall be developed based on each provider's historical costs as reflected in its base year cost report and allocated to three components, which are subject to component cost ceilings.

(d) A proprietary provider shall receive the GET and ROE adjustments to its basic PPS rate to account for gross excise taxes and return on equity.

(e) All providers shall receive the NF tax adjustment.

(f) For the FY 94 rebasing, all providers that reported recurring OBRA 87 costs on the OBRA 87 addendum used for the FY 94 rebasing are eligible to receive the OBRA 87 adjustment. Only the documented, allowable, reasonable and incremental cost of complying

with OBRA 87 shall be included in calculating the OBRA 87 adjustment. For future rebasings, recurring and reasonable OBRA 87 compliance costs shall be included in the costs that are considered in calculating the basic PPS rates.

(g) Rates for acute facilities with federally designated swing beds shall be established according to 42 C.F.R. §447.280.

(h) Changes in ownership, management, control, operation, and leasehold interests which result in increased costs for the successor owner, management, or leaseholder shall be recognized for purposes of reimbursement only to the following extent: Pursuant to the provisions of Pub. L. No. 99-272, section 9509 (a)(4)(C) the valuation of capital assets, shall not be increased, as measured from the date of acquisition by the seller to the date of the change of ownership, solely as a result of a change of ownership, by more than the lesser of:

(1) One-half of the percentage increase (as measured over the same period of time, or, if necessary, as extrapolated retrospectively by the Secretary) in the Dodge Construction Systems Costs for Nursing Home, applied in the aggregate with respect to those facilities which have undergone a change of ownership during the fiscal year, or

(2) One-half of the percentage increase (as measured over the same period of time) in the Consumer Price Index for all Urban consumer (United States city average).

(i) The department shall pay the providers separately for ancillary services based on a fee schedule or through an ancillaries payment.

(j) Nursing facilities that have G&A or capital costs below the median for their peer group are rewarded with an incentive payment.

(k) Members of the public may obtain the data and methodology used in establishing payment rates for providers by following the procedures defined in the Uniform Information Practices Act, chapter 92F, HRS. [Eff 11/13/95; am 11/25/96] (Auth: HRS §346-59; 42 U.S.C. §1396a) (Imp: 42 C.F.R. §447.252)

§17-1739-24 Services included in the basic PPS rate. (a) The reasonable and necessary costs of providing the following items and services shall be

included in the basic PPS rate and shall not be separately reimbursable, unless specifically excluded under subsection (b):

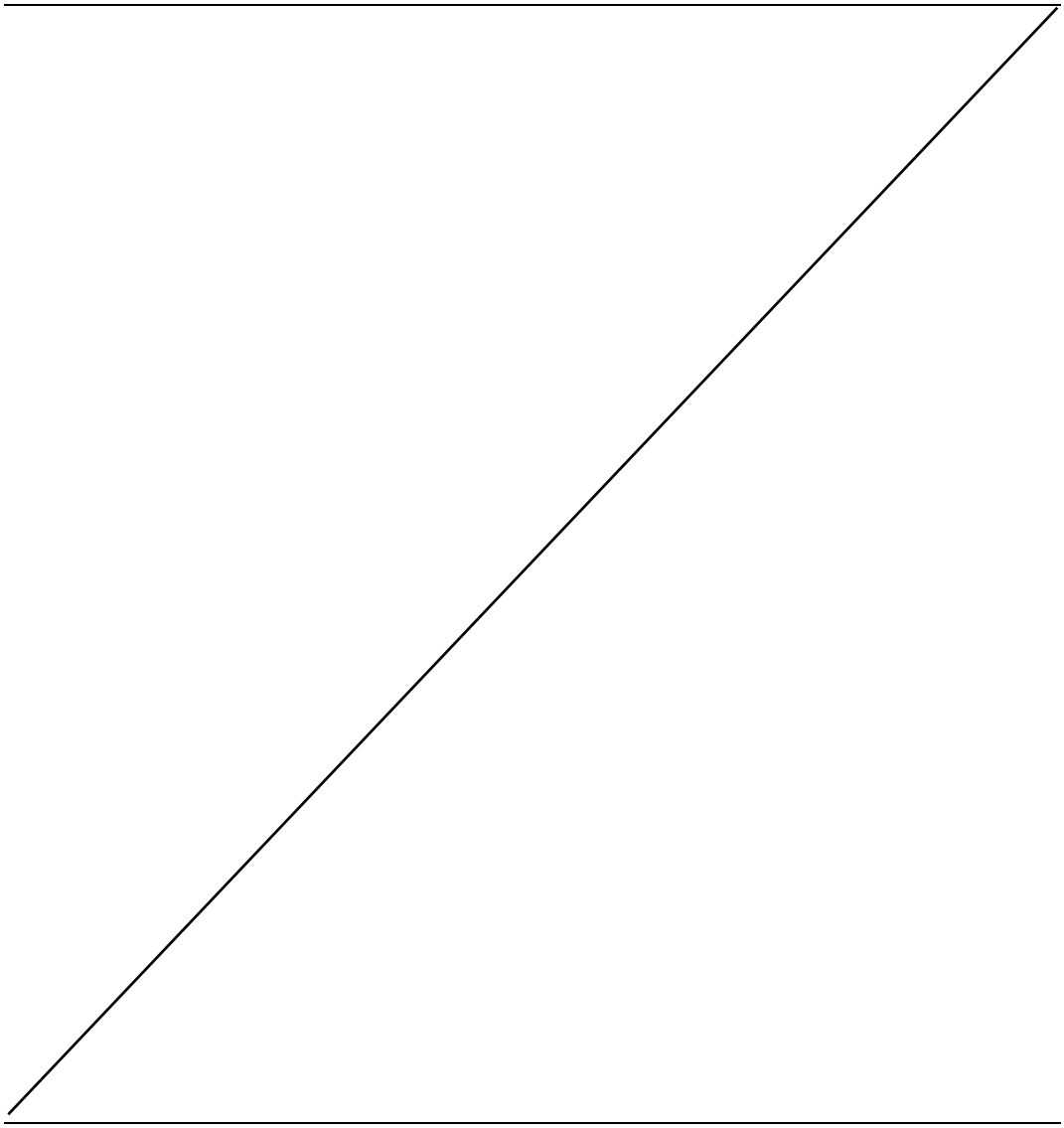
(1) Room and board;
(2) Administration of medication and treatment and all nursing services;
(3) Development, management, and evaluation of the written patient care plan based on physician orders that necessitate the involvement of skilled technical or professional personnel to meet the recipient's care needs, promote recovery, and ensure the recipient's health and safety;
(4) Observation and assessment of the recipient's unstable condition that requires the skills and knowledge of skilled technical or professional personnel to identify and evaluate the recipient's need for possible medical intervention, modification of treatment, or both, to stabilize the recipient's condition;
(5) Health education services, such as gait training and training in the administration of medications, provided by skilled technical or professional personnel to teach the recipient self-care;
(6) Provision of therapeutic diet and dietary supplement as ordered by the attending physician;
(7) Laundry services, including items of recipient's washable personal clothing;
(8) Basic nursing and treatment supplies, such as soap, skin lotion, alcohol, powder, applicators, tongue depressors, cotton balls, gauze, adhesive tape, Band-Aids, incontinent pads, V-pads, thermometers, blood pressure apparatus, plastic or rubber sheets, enema equipment, and douche equipment;
(9) Non-customized durable medical equipment and supplies used by individual recipients, but which are reusable. Examples include items such as ice bags, hot water bottles, urinals, bedpans, commodes, canes, crutches, walkers, wheelchairs, and side-rail and traction equipment;
(10) Activities of the patient's choice (including religious activities) that are designed to

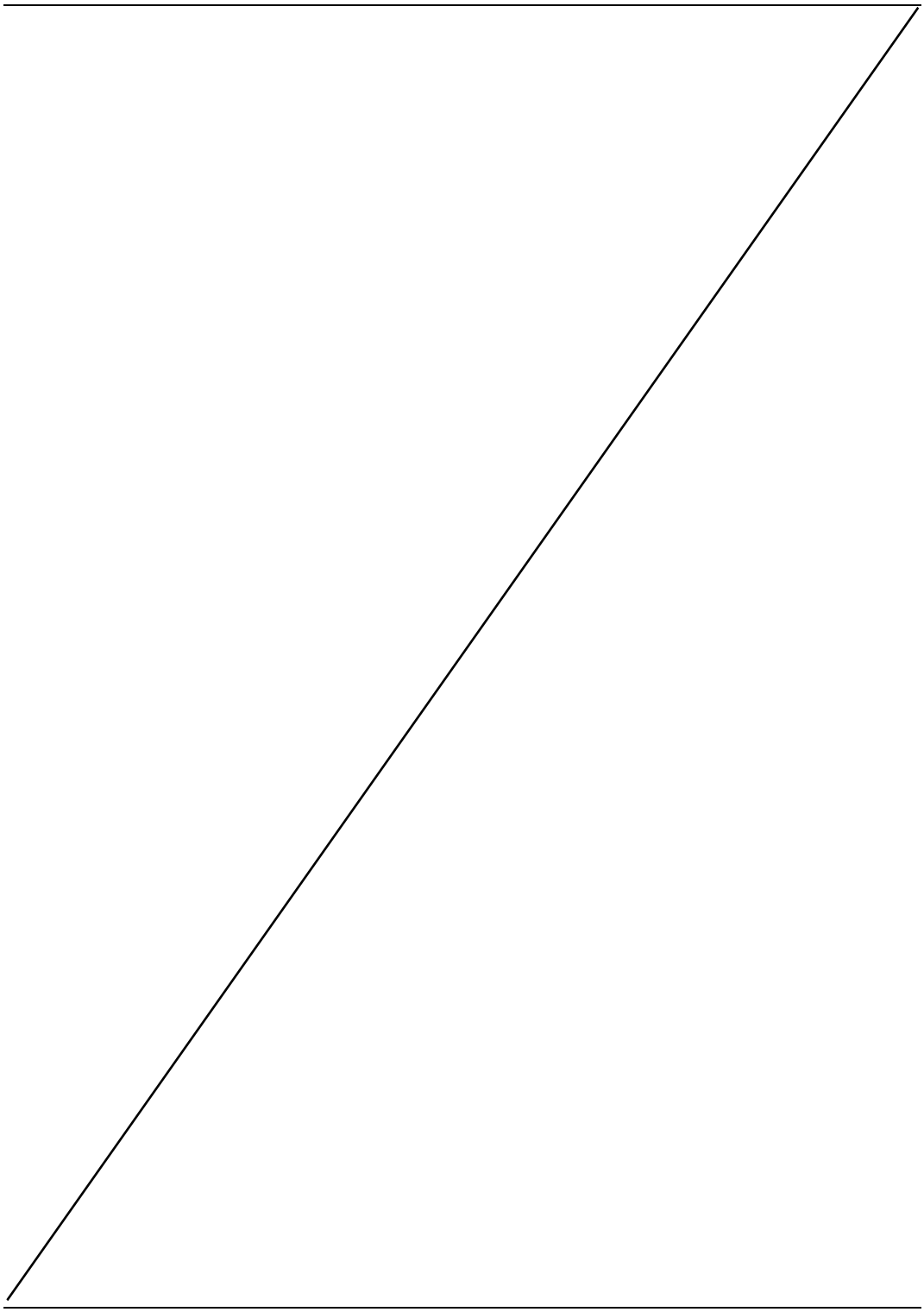
provide normal pursuits for physical and psychosocial well being;

(11) Social services provided by qualified personnel;

(12) Maintenance therapy; provided, however, that only the costs that would have been incurred if nursing staff had provided the Maintenance therapy will be included in calculating the basic PPS rates;

(13) Provision of and payment for, through contractual agreements with appropriate





skilled technical or professional personnel, other medical and remedial services ordered by the attending physician which are not regularly provided by the provider. The contractual agreement shall stipulate the responsibilities, functions, objectives, services fee, and other terms agreed to by the provider and the person or entity that contracts to provide the service; and

(14) Recurring, reasonable and incremental costs incurred to comply with OBRA 87.

(b) The costs of providing the following items and services shall be specifically excluded from reimbursement under this plan, and shall be billed separately to the department by the providers:

(1) Physician services, except those of the medical director and quality assurance or drug use review board, or all three;
(2) Drugs that are provided to residents in accordance with Title XIX policy;
(3) Laboratory, x-ray, and EKG;
(4) Ambulance and any other transportation for medical reasons that is not provided by the provider and not included in the costs used to calculate the basic PPS rates;
(5) Dental;
(6) Optical;
(7) Audiology;
(8) Podiatry;
(9) Physical therapy, excluding maintenance therapy;
(10) Occupational therapy, excluding maintenance therapy;
(11) Speech and hearing therapies; and
(12) Customized durable medical equipment and such other equipment or items that are designed to meet special needs of a resident and are authorized by the department.
(13) Charges for ancillary services are not included in calculating the basic PPS rates and shall be paid as follows:
(A) Providers that have the capability shall bill the department separately for ancillary services;
(B) The department shall make an ancillaries payment to providers that it designates as incapable of billing for ancillary services on an itemized basis;

(C) In order to receive an ancillaries payment, the provider must make assurances satisfactory to the department that it is committed to acquiring the ability to bill on an itemized basis for ancillaries, and is pursuing that goal with all deliberate speed;

(D) As part of the FY 94 rebasing, the department shall identify ancillary services for which a provider lacks the ability to bill separately and calculate a per diem amounts as an ancillaries payment;

(E) No provider that receives an ancillaries payment shall otherwise bill the department separately on behalf of a Title XIX resident for any type of ancillary service that is included in calculating its ancillaries payment. A provider that receives an ancillaries payment must also implement procedures and assure the department that no other person or entity will bill separately for any type of ancillary service that is included in calculating the ancillaries payment;

(F) The provider shall provide to the department upon request the progress that it is making in its efforts to acquire the ability to bill separately for ancillary services. If and when the provider acquires that ability, then it shall promptly notify the department in writing before separate billing is initiated;

(G) Once the department determines that a provider is capable of billing for some or all ancillary services on an itemized basis, then it shall provide advance written notice to that provider of a date upon which it will either cease making or reduce the ancillaries payment. If the provider acquires the capability of billing for some (but not all) ancillary services that were included in calculating its ancillaries payment, then the department shall

reduce the ancillaries payment accordingly; and

(H) The department shall make available all necessary data to ensure the appropriate accounting for ancillary services.

(c) The personal funds of medical assistance recipients may not be charged any costs for routine personal hygiene items and services provided by the provider. [Eff 11/13/95] (Auth: HRS §346-59; 42 U.S.C. §1396a) (Imp: 42 C.F.R. §447.252)]

§17-1739-25 Classification of long-term care providers into peer groups. For the purpose of establishing the basic PPS rates, providers and costs shall be grouped into the following five mutually exclusive classifications or peer groups:

(1) The costs of delivering care to acuity level A patients in free-standing nursing facilities;

(2) The costs of delivering care to acuity level C patients in free-standing nursing facilities;

(3) The costs of delivering care to acuity level A patients in hospital-based nursing facilities;

(4) The costs of delivering care to acuity level C patients in hospital-based nursing facilities; and

(5) The costs of delivering care to acuity level B patients in intermediate care facility for the mentally retarded. [Eff 11/13/95] (Auth: HRS §346-59; 42 U.S.C. §1396a(30)) (Imp: 42 C.F.R. §447.252)]

§17-1739-26 Basic PPS rate calculation methodology for existing providers. Unless otherwise noted, the basic PPS rates for existing providers shall be calculated using the methodology set forth in this subchapter. [Eff 11/13/95] (Auth: HRS §346-59; 42 U.S.C. §1396a) (Imp: 42 C.F.R. §447.252)

§17-1739-27 Data sources for rate calculation. (a) The department shall select the base year. The base year selected shall be the most recent state fiscal year for which cost reports for the significant

majority of providers are available. The department shall select the most recent year for which cost reports for the significant majority of providers are available but are not finally settled (i.e., the "as filed" cost reports). The department shall identify and apply an audit adjustment factor to the "as filed" cost reports.

(b) Cost and census day data to be used in the development of the basic PPS rates shall be abstracted from the uniform cost report that is submitted to the medicaid agency by each provider. If the department determines that additional data is required, then additional cost data shall be solicited from the provider. [Eff 11/13/95] (Auth: HRS §346-59; 42 U.S.C. §1396a) (Imp: 42 C.F.R. §447.252)

§17-1739-28 Calculation of component per diem costs by reference to each provider's base year cost report. (a) Cost data shall be abstracted from the base year cost report and categorized into the following three components:

(1) Direct nursing costs shall include all allowable costs involved in the direct care of the patient. Examples of such costs include the following:
   (A) Salaries for nurses' aides, registered nurses, and licensed practical nurses not involved in administration;
   (B) The portion of employee fringe benefits that are properly allocated to those salaries, and nursing supplies;
   (C) Physician-ordered maintenance therapy, which is not billed directly to the department. The cost of maintenance therapy services provided by persons other than nursing staff shall be limited to an amount equivalent to the cost if performed by nursing staff or a physical therapy aide; and
   (D) Costs of medical supplies charged to patients.

(2) Capital costs, shall include all allowable capital related operating costs under Medicare reasonable cost principles of reimbursement, as defined in 42 CFR Chapter 413 of the long-term care facility or distinct part unit. Examples of such costs

include the following:
(A) Rent;
(B) Interest;
(C) Depreciation;
(D) Equipment or lease rental;
(E) Property taxes; and
(F) Insurance relating to capital assets.

(3) G&A costs shall include all additional allowable costs incurred in providing care to long-term care patients. Examples of such costs shall include the following:
(A) Dietary;
(B) Housekeeping;
(C) Laundry and linen;
(D) Operation of plant;
(E) Medical records;
(F) The costs of insuring against or paying for malpractice, including insurance premiums, attorneys' fees and settlements of claims; and
(G) The costs of fringe benefits properly allocated to employees involved in general and administrative duties.

(b) Costs allocated to line items on the base year cost report other than those components listed in subsection (a) or to inappropriate line items, shall be appropriately reclassified to the three components. Reclassification shall be performed by the department or its fiscal agent. After the FY 94 rebasing, the department shall not survey or solicit information from the providers for the purpose of reclassifying costs from one component to another. For the FY 94 rebasing only, providers will be allowed to reclassify maintenance therapy costs from the physical therapy cost center.

(c) Costs of services specifically excluded from the basic PPS rate under section 17-1739-24(b) shall be deleted from the costs identified in subsection (a) for purposes of the basic PPS rate calculation. This process shall involve identifying line items from the base year cost report or other financial records of the provider pertaining to the excluded services and subtracting these costs from the appropriate component. If a provider's base year cost report does not identify the costs of excluded services, then the department shall so advise the provider and request additional financial records. If the provider does not respond with appropriate information, then the department may

delete from the provider's costs an amount reasonably estimated to represent the costs of such excluded services.

(d) Cost reports for facilities which began operations after the beginning of the base year are not included in calculating the statewide weighted average per diem costs or used to calculate the provider's basic PPS rate.

(e) Costs attributable to new beds that are placed in service after the beginning of the base year are also not included in calculating the statewide weighted average per diem costs or used to calculate the portion of the provider's basic PPS rate that relates to the new beds.

(f) Where an existing facility has partial year cost reports from more than one owner or operator, the department may either select one of the partial year cost reports or combine the cost reports from the former and current owners or operators, or both. In either case, the cost reports shall be adjusted to approximate the costs that would have been incurred for a twelve-month period.

(g) Gross excise taxes paid on receipts, NF taxes, and any return on equity received by a for-profit provider shall be deleted from the costs used to calculate the basic PPS rate and shall be reimbursed separately.

(h) If a provider received a rate increase pursuant to a rate reconsideration request in the base year, and that increase is for a non-recurring cost, then the department may delete from the base year costs that are included in calculating the basic PPS rates an amount equal to the costs that were used to calculate the rate increase.

(i) If a provider received supplemental payments from the state with no federal matching funds for special services in the base year, then the department shall adjust the provider's base year costs to remove the differential cost of those special services in calculating the provider's basic PPS rates.

(j) The resulting component costs and return on equity shall be standardized to remove the effects of varying fiscal year ends. Costs are inflated from the end of each provider's fiscal year to a common point in time: the end of the state's fiscal year for which the rates are in effect. Therefore, facilities with fiscal years that end earlier receive a higher rate (more months) of inflation.

(k) To recognize annual inflationary cost increases, these standardized component costs shall be inflated as described in section 17-1739-33.

(l) For nursing facility providers, the portions of a provider's standardized and inflated costs (except for the costs of maintenance therapy services included in direct nursing costs and the costs of complying with OBRA 87) that are in excess of federal routine operating cost limits (excluding the add-on to those limits for OBRA 87 costs) for long-term care facilities shall be deleted from the costs used to calculate the basic PPS rates. The department shall apply the federal routine operating cost limits for urban Honolulu facilities to all nursing facilities.

(m) For the FY 94 rebasing only, the department shall do the following:

(1) Delete the costs of complying with OBRA 87 from the costs used to calculate the basic PPS rates; and

(2) Include the recurring and reasonable costs of complying with OBRA 87 in calculating that provider's OBRA 87 adjustment.

For all subsequent rebasings, the costs of complying with OBRA 87 shall be part of the basic PPS rate.

(n) Costs that are not otherwise specifically addressed in this plan shall be included in base year costs if they comply with HCFA Publication No. 15 standards.

(o) Legal expenses for the prosecution of claims in federal or state court against the State of Hawaii or the department incurred after September 30, 1988, shall not be included as allowable costs in determining the PPS per diem rates.

(p) A provider-specific per diem component cost shall be calculated by dividing the cost associated with each component identified in subsection (a) as adjusted in subsection (b) by the number of long-term care provider census days for each acuity level report on the cost report and segregated in accordance with the classifications in section 17-1739-25.

(q) For providers with both acuity levels A and C residents in the base year, per diem component rates shall be established as follows:

(1) Costs as reported on the base year cost report shall be used for the computation of the level A and level C per diem component rates for providers which report costs for

acuity levels A and C residents separately;

(2) If a provider reports combined costs for acuity levels A and C and does not segregate its direct nursing costs based upon a case mix method or study, then the department shall allocate the provider's direct nursing costs based upon the acuity ratio;

(3) Costs for the general and administrative component shall be allocated equally on a per diem basis between acuity levels A and C, or at the provider's option, allocated by the provider using the same case-mix index developed for nursing costs;

(4) Capital costs shall be allocated equally between Acuity levels A and C on a per diem basis; and

(5) In no case shall a provider's acuity level A per diem costs exceed its acuity level C per diem costs.

(r) Notwithstanding the foregoing, if a provider's base year cost report indicates that the provider had insufficient experience at a particular level of care, then its basic PPS rate for that level of care shall be computed as follows:

(1) The G&A and capital cost components shall remain the same for both levels of care;

(2) The provider shall receive the substitute direct nursing component for the level of care for which it had insufficient experience;

(3) If the provider allocated its costs between levels A and C, then the costs and days allocated to the level of care for which it had insufficient experience shall not be considered in calculating its basic PPS rates;

(4) If the provider did not allocate its costs between levels A and C, then no part of its costs or days shall be allocated to the level of care for which it had insufficient experience in calculating its basic PPS rates; and

(5) The calculation of the basic PPS rate for an acuity level in which the provider has insufficient experience shall also consider the adjustments that have been incorporated into the basic PPS rate for which sufficient

experience exists. [Eff 11/13/95] (Auth: HRS §346-59; 42 U.S.C. §1396a) (Imp: 42 C.F.R. §447.252)

§17-1739-29 Application of component rate ceilings. (a) Each provider's per diem cost components, as calculated in accordance with section 17-1739-28, shall be subject to component rate ceilings in determining a provider's basic PPS rates.

(b) For each classification identified in section 17-1739-25, component rate ceilings shall be established as follows:

(1) For each provider, multiply the provider-specific per diem component cost by the provider's total census days in the base period to determine total cost per component by provider. Any per diem component cost that is greater than two standard deviations above or below the statewide mean of the component cost shall be excluded in calculating the component rate ceilings;

(2) For each classification identified in section 17-1739-25, sum the providers and totals calculated in paragraph (1) to determine the total cost per component for each classification;

(3) Divide the classification component costs calculated in paragraph (2) by the total census days reported in the base year cost reports for all providers in the classification to determine an average cost per component by provider classification; provided, however, that if any per diem costs are excluded because they deviate more than two standard deviations from the statewide mean, then the days associated with those per diem costs shall also be deleted in calculating the average cost per component for the peer group; and

(4) Multiply the results of paragraph (3) above by the following factors to determine the cost component rate ceilings by each provider classification:

(A) General and Administrative-1.1;

(B) Capital-1.1; and

(C) Direct Nursing-1.15.

(c) Generally, each per diem cost component of a

provider's basic PPS rates shall be the lesser of the provider's per diem cost component rate calculated under section 17-1739-28 or the per diem ceiling for that component. In the case of the capital component, no provider shall receive less than $1.50 a day regardless of its cost per day.

(d) If a provider's rate includes a substitute direct nursing component, then all three of the component ceilings that apply to the acuity level for which the rate is being calculated shall be applied.

(e) The component ceilings shall not be applied in the following circumstances:

(1) To a grandfathered PPS rate;

(2) To a grandfathered capital component (except as provided in section 17-1739-32(c)(1)(B);

(3) To grandfathered direct nursing and G&A components; and

(4) To a new provider or provider with new beds whose basic PPS rates are, in whole or in part, calculated under the special provisions defined in section 17-1739-30. That section defines the circumstances in which either the component ceilings or some other ceilings will be applied.

(f) For the FY 94 rebasing only, the rate calculation for all providers, except those who are either new providers or who have new beds, include the higher of the rates calculated under the following two options:

(1) Sections 17-1739-28 and 17-1739-29 and increased by the GET and ROE adjustments and capital and G&A incentives, if applicable; or

(2) The grandfathered PPS rate, which excludes OBRA 1987 payments, but includes rate reconsideration;

(3) If the grandfathered PPS rate is the lower of the two options, then the provider shall receive the basic PPS rate and all other appropriate adjustments that are defined in this plan.

(4) If the grandfathered PPS rate is the higher of the two options, then the provider shall also receive the following adjustments or increases to that rate:

(A) The NF tax and OBRA 87 adjustments, if applicable;

(B) Any rate increase granted pursuant to the rate reconsideration process; and

(C) For FY 94, one-half of the inflation adjustment. For all subsequent PPS years, the provider shall receive the same inflation adjustments that are received by all other providers.

(D) The GET adjustment, however, shall only be applied to the incremental increase to the total PPS rates that results from the adjustments or increases noted above. [Eff 11/13/95] (Auth: HRS §346-59; 42 U.S.C. §1396a) (Imp: 42 C.F.R. §447.252)

§17-1739-30 Treatment of new providers without historical costs. (a) The following two types of providers shall have their basic PPS rates calculated, in whole or in part, under this section:

(1) A provider that began operating after the base year, and therefore has no base year cost report; or

(2) A provider that began operating a new facility during the base year, and therefore has no base year cost report that reflects a full twelve months of operations.

(b) A provider that qualifies under one of the above criteria shall submit its projected costs to the department on forms and in the format defined by the department.

(c) The qualifying provider shall receive as its basic PPS rate the lesser of: its reasonable projected allowable costs under Medicare reasonable cost principles of reimbursement as defined in 42 CF.R. Chapter 413 and modified by this plan or one hundred twenty-five per cent of the sum of the statewide weighted averages for its peer group in each acuity level.

(d) In PPS rate years following the calculation of per diem rates under this section, the provider's basic PPS rates shall receive the same inflation adjustments as other providers. [Eff 11/13/95] (Auth: HRS §346-59; 42 U.S.C. §1396a(13)) (Imp: 42 C.F.R. §447.252)

§17-1739-30.1 Treatment of providers of the subacute level of care. Providers of the subacute level of care will be reimbursed as two groups, group I

being ventilator dependent recipients and group II being other recipients who require the subacute level of care. Reimbursement for group I and group II will be at a rate determined by the department until data is available. Thereafter, reimbursement will be calculated using PPS methodology. [Eff 11/25/96] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. 431.10)

§17-1739-31 Treatment of new beds without historical costs. (a) A provider that has expanded beds since or during the base year, and therefore has no base year cost report reflecting a full 12 months of operation with the new beds, shall have its basic PPS rates calculated, in whole or in part, under this section.

(b) Existing providers which add new beds during or after the base year shall receive basic PPS rates that "blend" the rates for the old and new beds.

(c) Basic PPS rates associated with the new beds shall be calculated in accordance with section 17-1739-31(c). If applicable, the GET adjustment shall be increased to cover the higher gross excise taxes that will result and the ROE adjustment shall be increased to reflect any equity invested in the new beds.

(d) The result of subsection (c) above shall be multiplied by the number of new beds.

(e) The basic PPS rates calculated on the historical costs of the existing beds as defined in sections 17-1739-27, 17-1739-28, and 17-1739-29 shall be multiplied by the number of existing beds.

(f) The sum of subsections (d) and (e) above shall be divided by the total number of existing and new beds.

(g) The rates calculated in subsection (f) above shall be the provider's basic PPS rate for all beds.

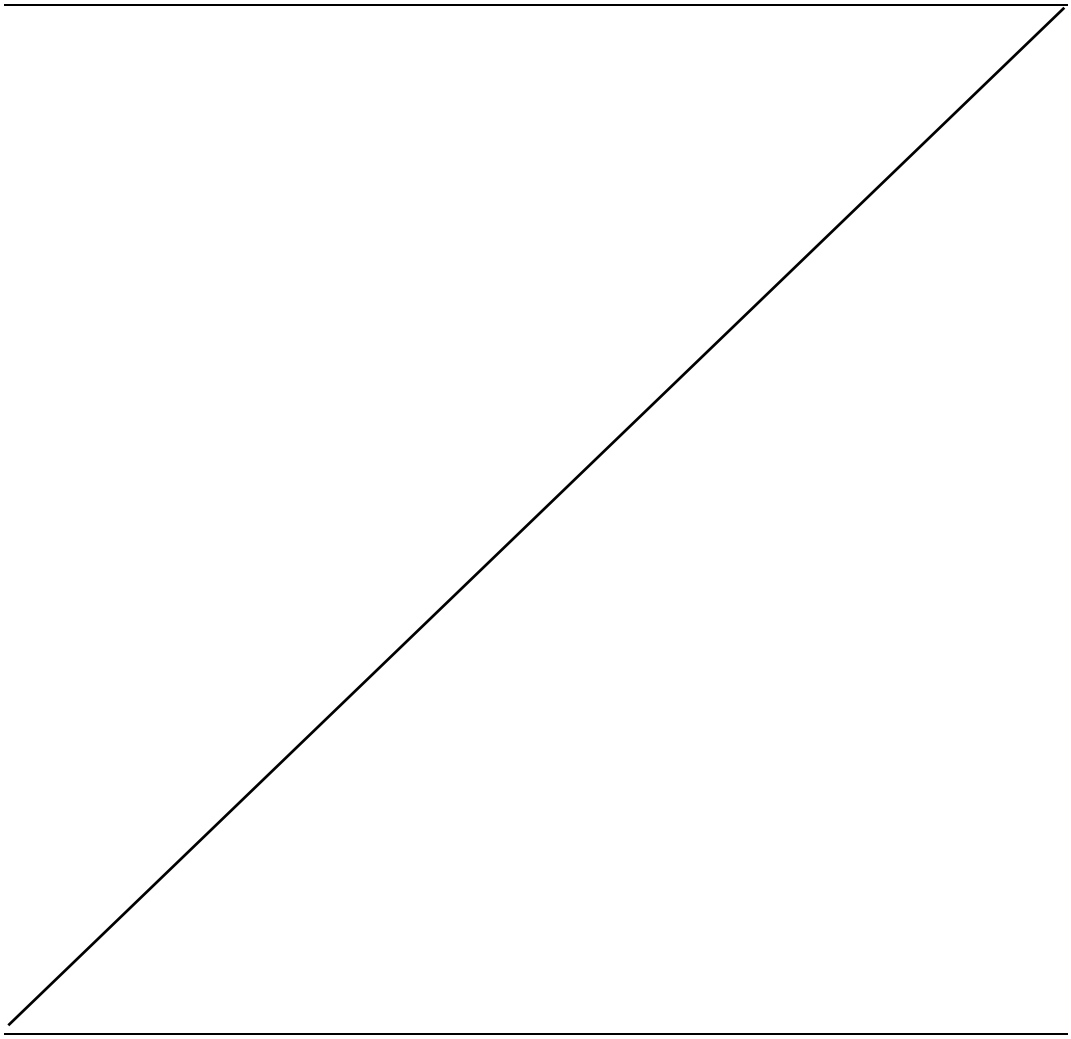
(h) The computation shall be performed separately for each acuity level. [Eff 11/13/95] (Auth: HRS §346-59; 42 U.S.C. §1396a) (Imp: 42 C.F.R. §447.252)

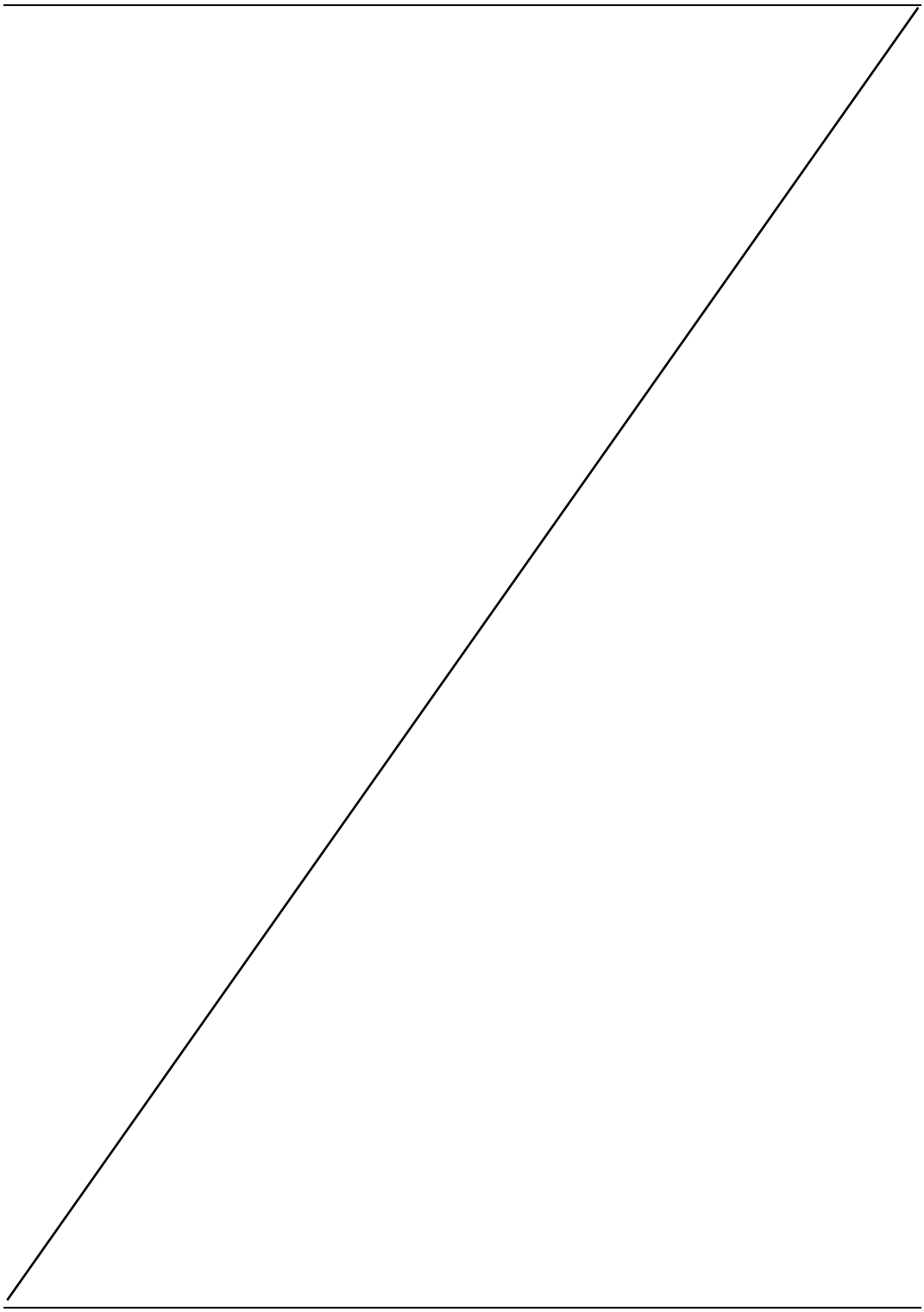
§17-1739-32 Transition of new providers and new beds into the PPS. (a) A new provider or a provider with new beds shall eventually have its basic PPS rates

calculated in the same manner as other providers. The transition will begin with the first rebasing in which the new provider or provider with new beds has a base year cost report that reflects a full twelve months of operations.

(b) Unless the provider is eligible for the grandfathered direct nursing and G&A components, the G&A and direct nursing components of the provider's basic PPS rates shall be calculated in the same manner as existing providers. This calculation shall include the application of the component ceilings.

(c) For new providers or providers that added new beds, the capital component of the basic PPS rates shall be determined as follows:





(1) The new provider or provider with new beds shall receive the lesser of the following two options as the capital component of its basic PPS rates:
(A) Its facility-specific capital per diem costs calculated in the same manner as existing providers (excluding the application of the capital component ceiling); or
(B) Its grandfathered capital component (excluding the application of the capital component ceiling); provided, however, that if the provider's facility-specific capital per diem amount after the application of the capital component ceiling is higher than its grandfathered capital component, then the provider shall receive the higher amount as the capital component of its basic PPS rates.

(2) In order to implement the preceding section, the department shall identify the capital component of the basic PPS rates for new providers that existed immediately prior to the implementation of the FY 94 rebasing. That amount, which is the grandfathered capital component, shall be calculated as follows:
(A) The department shall compare the new provider's projected per diem costs, which were used to establish its initial PPS rates, with its actual capital per diem costs as indicated on the base year cost report to determine whether the projected capital costs were reasonable. If the department concludes that the projections were unreasonable, then the department may adjust the grandfathered capital component accordingly;
(B) If the new provider's projected aggregate costs in all three PPS rate components exceeded one hundred twenty five percent of the sum of the statewide weighted averages, then the grandfathered capital component shall be reduced pro rata. That reduction shall be accomplished by multiplying the projected capital per diem by the capital component reduction factor; and
(C) After applying the capital component reduction factor, the new provider's

initial projected capital per diem amount shall be increased by the inflation factor to remove the effects of varying fiscal year ends and to inflate the per diem to the PPS year. That amount shall be the capital component of the new provider's basic PPS rates.

(3) The department shall follow the same general procedure in calculating the portion of the capital component for new beds that was used to calculate the blended capital component for providers with new beds. That process shall include the following steps:

(A) Identifying the grandfathered capital component;

(B) If appropriate, applying the capital component reduction factor;

(C) Determining whether the facility-specific or grandfathered capital component rate is appropriate; and

(D) Using the appropriate amount to calculate a "blended" capital per diem amount for the provider.

(d) A provider that added new beds and meets the defined eligibility tests is entitled to have its direct nursing and general administrative components adjusted as defined below:

(1) In order to be eligible for the grandfathered direct nursing and G&A components, a provider must meet the following requirements:

(A) The provider must have both old and new beds;

(B) The provider must have a full twelve months of historical costs for the new beds reflected in the base year cost report; and

(C) Immediately prior to the effective date of the FY 94 rebasing, the provider must have had in effect a "blended" basic PPS rate that included the costs of both the old and new beds;

(D) The provider's adjusted PPS rate for FY 94 (excluding the NF and OBRA 87 adjustments) is less than its total PPS rate immediately prior to the rebasing plus one-half the FY 94 inflation adjustment.

(2) A provider who meets the eligibility tests defined above shall receive the grandfathered direct nursing and G&A adjustment. As part of the calculation to determine the amount of the adjustment, one-half of the inflation adjustment for FY 94 is included. For FY 94 only, no other inflation adjustment shall be included in calculating the provider's adjusted PPS rates. Thereafter, the provider shall receive the full inflation adjustment in calculating its adjusted PPS rates. [Eff 11/13/95] (Auth: HRS §346-59; 42 U.S.C. §1396a) (Imp: 42 C.F.R. §447.252)

§17-1739-33 Application of inflation and other adjustments to establish provider-specific prospective payment rates. (a) Annual cost increases shall be recognized by applying the inflation adjustment to the historical costs or basic PPS rates, or both, with the exception of subsection (c)(1).

(b) For years in which the department performs a rebasing, cost increases attributable to inflation that has occurred since the base year shall be recognized as follows:

(1) The basic PPS rates shall be standardized to remove the effects of varying fiscal year ends;

(2) The basic PPS rates shall be multiplied by one plus the cumulative inflation adjustment;

(3) For the purpose of determining the inflation adjustment, the department shall use the most current and accurate data that is then available; and

(4) To ensure the prospective nature of the system, the data shall not be retroactively modified or adjusted.

(c) For years when the department does not perform a rebasing, cost increases due to inflation for the upcoming rate year shall be recognized as follows:

(1) The department shall multiply the adjusted PPS rate (excluding any rate reconsideration increases) in effect on June 30th of the immediately preceding fiscal year by one plus the inflation adjustment for the following state fiscal year. Except for the rate period commencing July 1, 1998 through June 30, 1999, the inflation factor would be zero; and

(2) To ensure the prospective nature of the payment methodology, the inflation adjustment shall not be retroactively modified or adjusted. [Eff 11/13/95; am] (Auth: HRS §346-59; 42 U.S.C. §1396a) (Imp: 42 C.F.R. §447.252)

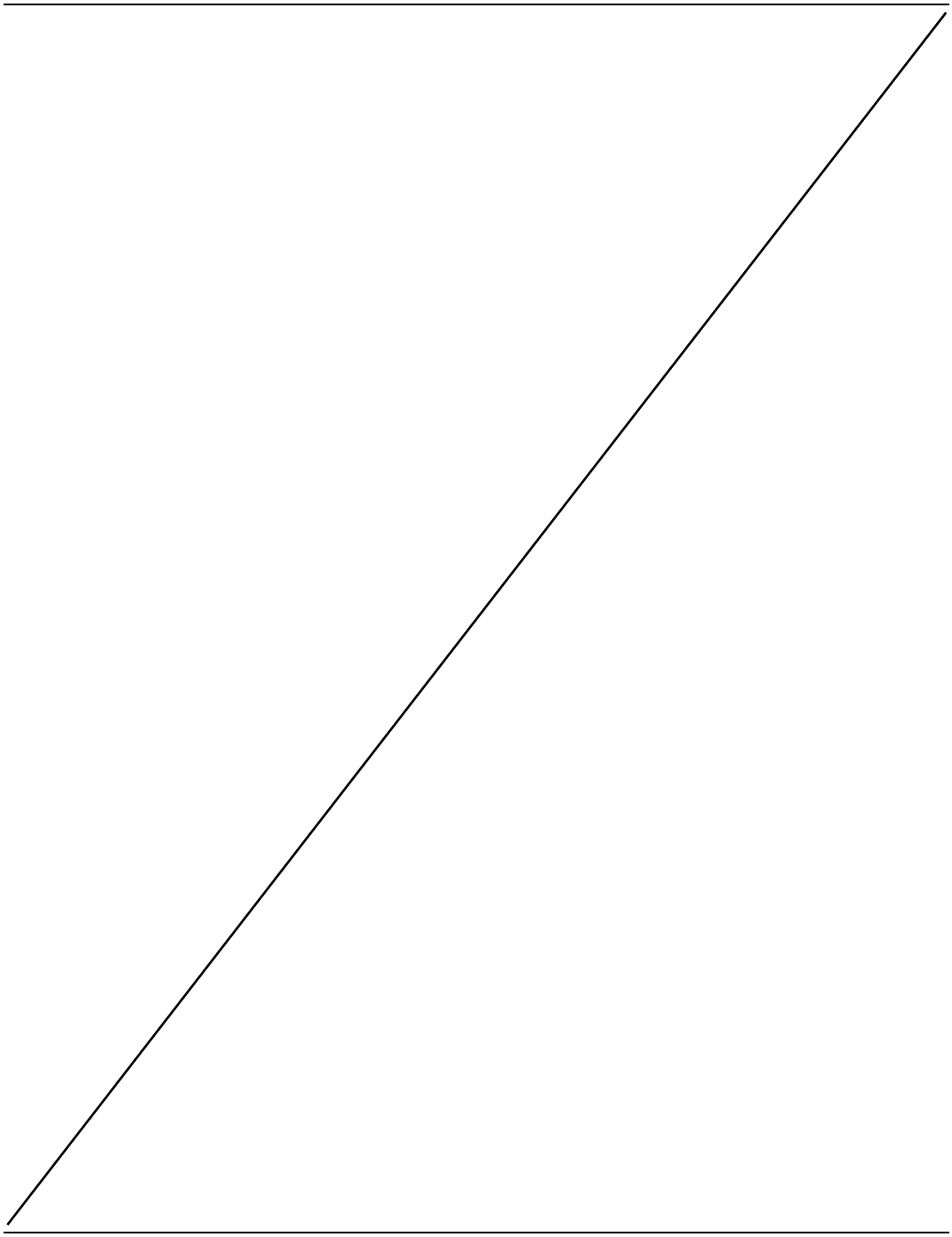
§17-1739-34 Limitations on long-term care provider reimbursement. (a) Notwithstanding any other provision of this plan, aggregate payments to each group of facilities (i.e., nursing facilities or intermediate care facility for the mentally retarded) may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare reasonable cost principles of reimbursement as defined in 42 C.F.R. Chapter 413. In addition, aggregate payments to each group of state-operated providers (i.e., nursing facilities or intermediate care facility for the mentally retarded) may not exceed the amount that can reasonably be estimated would have been paid under Medicare reasonable cost principles of reimbursement. If a formal and final determination is made that payments in the aggregate exceeded the upper limit and federal financial participation is disallowed, the department may recoup any payments made to providers in excess of the upper limit.

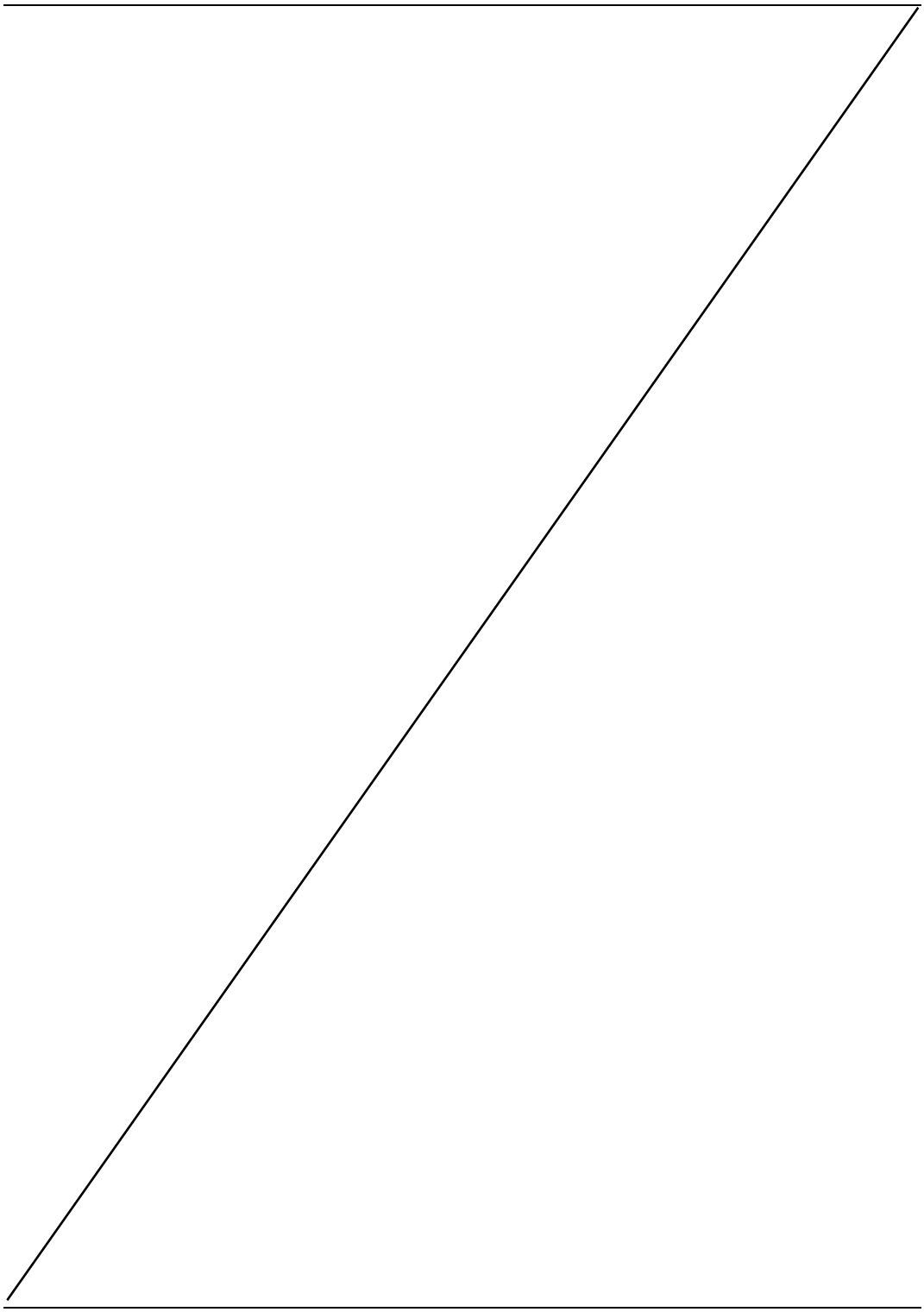
(b) Notwithstanding any other provisions of this plan, payment for out-of-state long-term care facility services shall be the lesser of the facility's charge, the other state's medicaid rate, or the statewide weighted average Hawaii medicaid rate applicable to services provided by comparable Hawaii providers.

(c) Notwithstanding any other provision of this plan, no payments shall be made for the improper admission of or care for mentally ill or mentally retarded individuals, as those terms are defined in section 4211 (e)(7)(G) of OBRA 87.
[Eff 11/13/95] (Auth: HRS §346-59; 42 U.S.C. §1396a(13)) (Imp: 42 C.F.R. §447.252)

§17-1739-35 Adjustments to base year cost. (a) Adjustments to a provider's base year cost report that occur subsequent to a rebasing that utilizes that base year cost report shall not result in any change to the component rate ceilings for the provider's peer group.

(b) Beginning with the FY 94 rebasing, if a provider's PPS rates are based upon a cost report that is not finally settled, the the department shall not





adjust those rates based upon subsequent changes to the base year cost report; provided, however, that the provider may seek revisions to that base cost report at the first available opportunity to seek a rate reconsideration. This shall apply to changes to a base year cost report that are made after a rebasing occurs.

(c) The PPS rate calculation process is complex and requires an extensive commitment of the department's resources. Occasionally, the department may uncover or have brought to its attention minor data extraction or calculation errors that affect one or a few providers. Unless the department reasonably expects the correction of an error for one or a few providers to have a significant impact on the statewide weighted averages or component ceilings, the department need not recalculate those averages or ceilings to reflect a recalculation of the basic PPS rates of the one or few providers. [Eff 11/13/95] (Auth: HRS §346-59; 42 U.S.C. §1396a) (Imp: 42 C.F.R. §447.252)

§17-1739-36 Rebasing the basic PPS rates. The department shall perform a rebasing following the methodology but using updated cost report data as described in section 17-1739-27 so that a provider shall not have its basic PPS rates calculated by reference to the same base year for more than four state fiscal years. [Eff 11/13/95] (Auth: HRS §346-59; 42 U.S.C. §1396a) (Imp: 42 C.F.R.§447.252)

§17-1739-37 Adjustments to the basic PPS rates. (a) Each proprietary provider is eligible to receive the ROE adjustment. The ROE adjustment shall be calculated by identifying the appropriate amounts from the base year cost report or other sources, and dividing those amounts by the provider's base year patient days to obtain a base year ROE per diem. The base year ROE adjustments shall receive the same increase to reflect inflation as all other base year costs.

(b) All proprietary providers shall receive the GET adjustment. The GET adjustment shall be paid by increasing the basic PPS rates plus all applicable adjustments by 1.04167.

(c) All providers shall receive the NF tax adjustment. The NF tax adjustment shall be paid by

increasing the basic PPS rates plus all applicable adjustments by 1.06. Notwithstanding the foregoing:

(1) The effective date of the NF tax adjustment shall coincide with the effective date of the NF tax; and

(2) If the Act imposing the NF tax is repealed or otherwise expires, then the providers shall cease receiving the NF tax adjustment concurrent with the cessation of the imposition of the tax.

(d) For the FY 94 rebasing only, all providers that report recurring costs of complying with OBRA 87 shall receive the OBRA 87 adjustment, which shall be computed and paid as follows:

(1) The department shall compute a per diem amount by dividing all recurring reasonable and incremental OBRA 87 costs by the cumulative number of patient/days in the base year;

(2) For the purpose of adjusting the level A rate for freestanding facilities only, the adjustment shall be increased by $1 a day to recognize that complying with OBRA 87 requires greater operational changes (and higher costs) in that context than any other;

(3) Commencing with the PPS year that begins July 1, 1994, the base year OBRA 87 adjustment shall receive the same inflation adjustment as all other components of the basic PPS rates.

(e) Beginning with the FY 94 rebasing, nursing facilities who qualify shall receive the capital incentive adjustment, the G&A incentive adjustment, or both. Due to the limited number of ICF/MRs, those facilities shall not be eligible to receive either the Capital Incentive or G&A incentive adjustments.

(f) For the PPS rate years ending June 30, 1994 and June 30, 1995 only, freestanding providers located on the Island of Kauai shall receive the Hurricane Iniki adjustment. Beginning July 1, 1995, these providers shall receive the PPS rates that are calculated pursuant to the other provisions of this plan.

(g) Total PPS rates - A provider's basic PPS rates shall equal the sum of its direct nursing, G&A and capital per diem components for each acuity level as calculated under this plan. A new provider's basic PPS rate shall be the per diem rate calculated under

the provision of section 17-1739-31. The basic PPS rate for a provider with new beds shall be the per diem rate calculated under the provisions of section 17-1739-32.

(h) Except for providers that receive the Hurricane Iniki adjustment, a provider's adjusted PPS rate shall be the product of the following formula:

Basic PPS Rate
+ Capital Incentive Adjustment (if applicable)
+ G&A Incentive Adjustment (if applicable)
+ ROE Adjustment (if applicable)
+ OBRA 87 Adjustment (if applicable)
Subtotal

(Subtotal x GET Adjustment (if applicable))
+ (Subtotal x NF Tax Adjustment)
Adjusted PPS Rate

(i) A provider's total PPS rate shall be the adjusted PPS rate plus any rate increases granted pursuant to rate reconsideration requests. [Eff 11/13/95] (Auth: HRS §346- 59; 42 U.S.C. §1396a (13) (Imp: 42 C.F.R. §447.252)

§17-1739-38 Administrative review - rate reconsideration. (a) Providers shall have the right to request a rate reconsideration for the following conditions:

(1) A change in ownership, leaseholder, or operator, without a change in licensure and certification, which shall be grounds for rate reconsideration only to the extent authorized in section 17-1739-23(h);

(2) Extraordinary circumstances including, but not limited to, the following: acts of God; changes in life and safety code requirements; changes in licensure law or rules or regulation; significant changes in patient mix or nature of service occurring subsequent to the base year; errors by the department in data extraction or calculation of the per diem rates; subject to section 17-1739-35, inaccuracies or errors in the base year cost report; or additional capital costs resulting from renovation of a facility that does not result in additional beds but otherwise are

attributable to extraordinary circumstances. Mere inflation of costs, absent extraordinary circumstances, shall not be a basis for rate reconsideration. Providers who receive the Hurricane Iniki adjustment will not be able to file for a rate reconsideration under this section for damages caused by Hurricane Iniki;

(3) To determine in advance the amount of rate reconsideration relief, if any, that will be granted to the provider for an anticipated future cost in excess of $50,000, or $1,000 per bed, whichever is less. The provider must be otherwise ready to incur the cost, and it must be attributable to a proposed capital expenditure, change in service or licenser or extraordinary circumstance. Any determination by the department is subject to the provider actually incurring the anticipated cost. If the actual cost is greater or lesser than the anticipated future cost submitted by the provider, then the department may adjust its rate reconsideration relief determination either on its own initiative or by supplemental request of the provider. A provider that fails to request an advance rate reconsideration from the department assumes the risk that no rate reconsideration relief may ultimately be available; and

(4) If the department reduces the grandfathered capital component of a new provider or a provider with new beds due to an inaccurate or unreasonable projection of capital costs by the provider.

(b) Requests for reconsideration shall be submitted in writing to the department and shall set forth the reasons for the requests. Each request shall be accompanied by sufficient documentation to enable the department to act upon the request. Documentation shall include the data necessary to demonstrate that the circumstances for which reconsideration is requested meet one or more of the conditions specified in subsection (a). The requests shall include the following:

(1) A presentation of data to demonstrate the reasons for the provider's request for rate reconsideration;

(2) If the reconsideration request is based on changes in patient mix, the provider must document the change using well-established case-mix measures, accompanied by a showing of cost impact; and

(3) A demonstration that the provider's costs exceed the payments under this plan.

(c) Except as otherwise provided in this plan, a request for reconsideration shall be submitted within sixty days after the annual PPS rate is provided to the provider by the department, or at other times throughout the year if the department determines that extraordinary circumstances occurred or if the circumstances defined in subsection (a)(1) occur.

(d) Pending the department's decision on a request for rate reconsideration, the provider shall be paid the PPS rate initially determined by the department. If the reconsideration request is granted, the resulting new PPS rate shall be effective no earlier than the first date of the PPS rate year.

(e) A provider may appeal the department's decision on the rate reconsideration request. The appeal shall be filed in accordance with the procedural requirements of chapter 17-1736, subchapter 3, of the Hawaii Administrative Rules.

(f) Except as noted below, rate increases granted pursuant to the rate reconsideration process shall not exceed an amount equal to the sum of the component ceilings for a particular provider's classification minus the provider's basic PPS rate:

(1) If a provider is either new or has added new beds and its basic PPS rate is calculated under sections 17-1739-30, 17-1739-31, or 17-1739-32, then a rate increase shall not exceed the difference between the sum of the ceilings for the direct nursing and general and administrative components and the sum of the provider's facility-specific components for those categories;

(2) If a provider is receiving the grandfathered capital component, then the increase shall not exceed the difference between the sum of the direct nursing and G&A component ceilings and sum of the provider's direct nursing and G&A components;

(3) If a provider seeks a rate increase to cover costs of complying with OBRA 87 and otherwise would be disabled from receiving an increase

by the application of the sum of the component ceilings, then the department may grant an additional increase up to the amount of the mean OBRA 87 adjustment for the provider's peer group. The mean OBRA 87 adjustment shall be calculated pursuant to section 17-1739-37(d) and shall receive the inflation adjustment (if any) that is defined in that section.

(g) Rate reconsideration granted under this section shall be effective for the remainder of the PPS rate year. If the provider believes its experience justifies continuation of the rate in subsequent rate years, it shall submit information to update the documentation specified in subsection (b) within sixty days after receiving notice of the provider's rate for each subsequent PPS rate year. The department shall review the documentation and notify the provider of its determination as described in subsection (d). The department may, at its discretion, grant a rate adjustment that will be incorporated into the provider's rate for one or more of the following PPS rate years.

(h) The decision to grant a rate reconsideration request is subject to the department's discretion. In exercising that discretion, the department may consider that a provider's adjusted PPS rate includes a grandfathered component or incentive adjustment. [Eff 11/13/95] (Auth: HRS §346-59; 42 U.S.C. §1396a) (Imp: 42 C.F.R. §447.252).

§17-1739-39 Cost report requirements. (a) All providers shall maintain an accounting system which identifies costs in a manner that conforms to generally accepted accounting principles.

(b) Participating providers shall submit the following on an annual basis no later than ninety days after the close of each provider's fiscal year:

(1) Uniform cost report;
(2) Working trial balance;
(3) Provider cost report questionnaire;
(4) If the provider has its financial statement audited, then a copy of that audited financial statement;
(5) Disclosure of appeal items included in the cost report; and

(6) Such other cost reporting and financial information as the department shall request. This information may include segregation of certain costs of delivering services to acuity level C residents as opposed to acuity level A residents.

(c) In subsequent years, the department may require providers to classify their costs according to the components as defined in section 17-1322-28 and interpretive guidelines provided by the department and submit that classification with its cost report. Final classification of costs into appropriate components shall be at the discretion of the department.

(d) Claims payment for services will be temporarily reduced twenty per cent if the cost report is not received within one-hundred twenty days, and one hundred per cent if the cost report is not received within one-hundred fifty days. A thirty day maximum extension shall be granted upon written request for good cause as provided in Medicare guidelines.

(e) Each provider shall keep financial and statistical records of the cost reporting year for at least six years after submitting the cost report form to the department and shall make such records available upon request to authorized state or federal representatives. [Eff 11/13/95] (Auth: HRS §346-59; 42 U.S.C. §1396a(27)) (Imp: 42 C.F.R. §447.252)

§17-1739-40 Audit requirements. (a) The department or its ~~fiscal agent shall~~ conduct periodically either on-site or desk audits of cost reports, including financial and statistical records of a sample of participating providers in each provider classification.

(b) Reports of the on-site or desk audit findings shall be retained by the department or its fiscal agent for a period of not less than three years following the date of submission of the report.

(c) Each provider shall have the right to appeal audit findings in accordance with the procedural requirements of Chapter 17-1736, Subchapter 3, of the Hawaii Administrative Rules. [Eff 11/13/95] (Auth: HRS §346-59; 42 U.S.C. § 1396a) (Imp: 42 C.F.R. §447.252)

§17-1739-41 Bed-hold requirements for long-term care. A medicaid recipient's bed may be reserved during a recipient's temporary absence from the long-term care facility if:

(1) The recipient's plan of care provides for absences other than for hospitalization, and is approved by the recipient's attending physician;

(2) Any single episode during which a bed is reserved does not exceed a period of three consecutive days, unless a request for prior approval is submitted to the program, reviewed, and approved by its medical consultant;

(3) The total number of days a recipient reserves a bed per calendar year does not exceed twelve days; and

(4) A record is maintained in the recipient's medical charges which accounts for the number of days and specific dates for any year that a recipient reserved a bed, subject to periodic review by the department's representatives. [Eff 11/13/95] (Auth: HRS §346-59; 42 U.S.C. §1396a) (Imp: 42 C.F.R. §447.252)

§17-1739-42 Effective date of amendments to subchapter 2. Unless otherwise stated, amendments to this subchapter 2 shall be effective concurrent with the effective date approved by the federal government for the Hawaii State Plan for reimbursement to long term care providers. [Eff 11/13/95] (Auth: HRS §346-59; 42 U.S.C. §1396a) (Imp: 42 C.F.R. §336.252)

§17-1739-43 to §17-1739-52 (Reserved).

SUBCHAPTER 3

PROSPECTIVE PAYMENT FOR ACUTE CARE SERVICES

§17-1739-53 Definitions. As used in this subchapter:

"Ancillary services" means diagnostic or

therapeutic services performed by specific facility departments as distinguished from general or routine patient care such as room and board. Ancillary services generally are those special services for which charges are customarily made in addition to routine charges, and they include such services as laboratory, radiology, surgical services, etc.

"Base year" means the state fiscal year used for initial calculation and recalculation of prospective payment rates. The base year shall be the most recent State fiscal year or years for which complete, finally-settled financial data is available. Base year data shall be supplemented with finally-settled cost data from previous years, if it is determined that extraordinary costs occurred in the most recent, finally-settled cost report. The 1983 state fiscal year shall be the base year for purposes of initial calculation of prospective payment rates.

"Break-even point" means the point at which a hypothetical special care percentage in the base year would not have resulted in the elimination of any costs due to the application of the ceiling factors in calculating the PPS rates.

"Capital related costs" means costs associated with the capital costs of the provider's facilities and equipment under Medicare principles of reimbursement. For purposes of the prospective payment methodology, capital related costs shall include depreciation, interest, property taxes, property insurance, capital leases and rentals, and costs and fees related to obtaining or maintaining capital related financing.

"Cash subsidies for patient services" means, without limitation, amounts appropriated by the state legislature or a local governmental entity, either as direct subsidies or general fund allotments, and paid to the provider.

"Charity care" means, without limitation, care for which the provider never expected or sought payment. Charity care includes care provided pursuant to the Hill-Burton program, but excludes cash subsidies for patient services as defined above.

"Claim charge data" means charges and other information obtained from billing claim forms processed by the medicaid fiscal agent.

"Costs" means total finally-settled allowable costs of acute inpatient services, unless otherwise specified.

"Discharge" means the release of a patient from an

acute care facility. The following events are considered discharges:

(1) The patient is formally released from the hospital;
(2) The patient is transferred to an out-of-state hospital;
(3) The patient is transferred to a long-term care level or facility;
(4) The patient dies while hospitalized;
(5) The patient signs out against medical advice; or
(6) In the case of a delivery where the mother and baby are discharged at the same time, release of the mother and her baby shall be considered two discharges for payment purposes. In cases of multiple births, each baby will be considered a separate discharge.
(7) A transfer shall be considered a discharge for billing purposes but shall not be reimbursed as a full discharge except as specified in section 17-1739-70(f)(1).

"Disproportionate share adjustment" means the largest of the following adjustments:

(1) Divide indigent acute inpatient days by total acute inpatient days. Each percentage point or fraction thereof in excess of fifteen per cent shall be converted to a decimal and added to 1.00 to obtain the disproportionate share adjustment;
(2) Calculate the facility's medicaid utilization rate and subtract one standard deviation above the statewide mean medicaid utilization rate. Each percentage point in excess of this standard deviation shall be converted to a decimal and added to 1.00 to obtain the disproportionate share adjustment. A calculation resulting in a fraction of a percentage point shall be rounded up to the next percentage point. When the medicaid utilization rate equals the rate at one standard deviation point, it will be considered a fraction of a percentage point and rounded up; or
(3) Calculate the facility's low income utilization rate and subtract twenty-five per cent. Each percentage point or fraction thereof in excess of twenty-five per cent shall be converted to a decimal and added to

1.00 to obtain the disproportionate share adjustment.

"Disproportionate share provider" means a facility that meets the following tests:

(1) Either --

(A) Has at least two obstetricians with staff privileges at the facility who have agreed to provide obstetric services to individuals who are eligible for assistance under the medicaid program; or

(B) Did not offer nonemergency obstetric services as of December 21, 1987; and

(2) Either --

(A) Has indigent inpatient days equal to or greater than fifteen per cent of total acute inpatient days;

(B) Has a medicaid utilization rate equal to or greater than one standard deviation above the statewide mean medicaid utilization rate; or

(C) Has a low income utilization rate equal to or greater than twenty-five per cent.

In applying the foregoing, the medicaid and total days and revenues shall be obtained from the facility's most recently filed cost report or related financial information for the period covered by that cost report. The Supplemental Security Income days shall be determined by the department based on the most recent information obtained from the Health Care Financing Administration. All other information shall be obtained from the most recent and reliable data available at the time the computation is made.

"Distinct part" means that portion of an acute care facility that is licensed to and provides long-term care services under subchapter 2.

"Indigent" means an individual who is considered eligible for Supplemental Security Income (SSI) or medicaid, or both.

"Inpatient" means a patient who is admitted to an acute care facility on the recommendation of a physician or dentist and who is receiving room, board, and other inpatient services in the hospital at least overnight, and requires services that are determined by the State to be medically necessary. A patient who is admitted to an acute care facility and expires while in the facility shall be considered an inpatient admission regardless of whether the stay was overnight.

Emergency room services are included in the PPS inpatient rate only when a patient is admitted from the emergency room.

"Low income" means medicaid eligible and indigent patients.

"Low income utilization rate" means the sum of the following:

(1) A fraction (expressed as a percentage)--

(A) The numerator of which is the sum (for a period) of (I) the total revenue paid the hospital for patient services under a state plan under Title XIX of the Social Security Act and (II) the amount of the cash subsidies for patient services received directly from state and local governments; and

(B) The denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies for patient services) in the period; and

(2) A fraction (expressed as a percentage)--

(A) The numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period; and

(B) The denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under subparagraph 2(A) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a state plan approved under Title XIX of the Social Security Act).

"Medicaid utilization rate" means a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under the state plan approved under Title XIX of the Social Security Act in a period, and the denominator of which is the total number of the hospital's inpatient days in that period.

"Medical education" means direct costs associated with an approved intern and resident teaching program as defined in the Medicare provider reimbursement manual, publication HIM-15.

"New provider" means a provider that does not have a cost report in the base year that reflects at least a full twelve months of operations.

"Operating year" means the twelve consecutive month period beginning on the latest of the following dates:

(1) The effective date of the plan amendment that adds this definition to the plan; or

(2) The date that a hospital becomes a provider.

"Outlier claims" means any claim which has total charges in excess of the outlier threshold, as defined in the State Plan.

"Outpatient" means a patient who receives outpatient services at a hospital which is not providing the patient with room and board and other inpatient services at least overnight. Outpatient includes a patient admitted as an inpatient whose inpatient stay is not overnight except in cases in which the patient expires.

"Provider" means a qualified and eligible facility that contracts with the department to provide institutional acute care services to eligible individuals.

"Routine services" means daily bedside care, such as room and board, serving and feeding patients, monitoring life signs, cleaning wounds, bathing, etc.

"Special care percentage" means the result of dividing the medicaid special care days for a given cost reporting period by the total medicaid days for the same period. The days reported in the nursery cost center on the cost report shall be excluded from the calculation.

"State plan" means the Hawaii medicaid State Plan for methods and standards for establishing payment rates - prospective reimbursement system for inpatient services.

"Wait listed patient" means a patient who no longer requires acute care and is awaiting placement to a long-term care facility. [Eff 11/13/95; am 01/29/96] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-54 Provider participation requirements for acute care facilities. medicaid reimbursement for acute care services shall be limited to those facilities which have:

(1) Applied to and been approved by the department of medicaid participation;

(2) Received certification or recertification from the state department of health under federal standards in force;
(3) Been licensed by the state department of health; and
(4) Entered into a nontransferable provider agreement with the department for no more than twelve months coterminous with the state department of health's certification period. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-55 Payment for acute care services - general provisions. (a) The Hawaii medicaid program shall reimburse qualified providers for inpatient institutional services based solely on the prospective payment rates developed for each facility as determined in accordance with this subchapter. The estimated average proposed payment rate under this subchapter is reasonably expected to pay no more in the aggregate for inpatient hospital services than the amount that the department reasonably estimates would be paid for those services under Medicare principles of reimbursement.

(b) A hospital-specific retrospective settlement adjustment shall be made for those providers whose medicaid charges are less than medicaid payments on the cost report and do not qualify as nominal charge providers under Medicare principles of reimbursement.

(c) Prospective rates shall be derived from historical f0acility costs, and facilities shall be classified based on discharge volume and participation in an approved intern and resident teaching program.

(d) Providers which average fewer than 250 medicaid discharges per year shall be classified as classification I facilities and shall receive payment based on either an all-inclusive psychiatric services per diem rate or an all-inclusive nonpsychiatric services per diem rate, which includes an adjustment for capital, disproportionate share, and medical education and, for proprietary facilities, return on equity and gross excise tax.

(e) Providers which average two hundred fifty medicaid discharges or more per year shall be separated into two facility classifications (classifications II and III) and shall receive payment based upon the type of services required by the patient. Psychiatric services will be paid on the basis of an all-inclusive

per diem rate. Nonpsychiatric claims will be designated as requiring either surgical, medical, or maternity care and will be paid on the basis of a routine per diem rate for the service type plus an ancillary per discharge rate for the service type. The per diem and per discharge rates shall include adjustments for capital, medical education, disproportionate share, and for proprietary facilities, return on equity and gross excise tax.

(f) The freestanding rehabilitation hospital shall be excluded from classifications I, II, and III and shall receive payment based on either an all-inclusive psychiatric services per diem rate or an all-inclusive nonpsychiatric services per diem rate, with the same adjustments noted above.

(g) Claims for payment shall be submitted following discharge of a patient, except as follows:

(1) Claims for nonpsychiatric inpatient stays which exceed $35,000 shall be submitted in accordance with section 17-1739-72;

(2) If a patient is hospitalized in the freestanding rehabilitation hospital for more than thirty days, the facility may submit an interim claim for payment every thirty days until discharge. The final claim for payment shall cover services rendered on all those days not previously included in an interim claim.

(h) The prospective payment rates shall be paid in full for each medicaid discharge. Hospitals may not separately bill the patient or the medicaid program for medical services rendered during an inpatient stay, except for outlier payments and as provided in section 17-1739-56 below.

(i) At the point that a patient reaches outlier status, the facility is eligible for interim payments computed pursuant to section 17-1739-72.

[Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-56 Services included in the prospective payment rate. The prospective payment rate shall include all services provided in an acute inpatient setting except:

(1) Professional component including physician services or any other professional fees excluded under Part A Medicare;

(2) Ambulance; and
(3) Durable medical equipment that is a take home item except for implanted devices.
[Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-57 Preparation of data for prospective payment rate calculation. (a) The calculation of prospective payment rates shall be based on facility-specific claims and cost data. Cost data shall be abstracted at the time the rate calculation begins from finally-settled uniform cost reports submitted to the department by each participating provider in accordance with federal medicaid requirements. Except for the disproportionate share adjustment, the cost report used for each facility shall be the facility's report which ended during the state fiscal year selected as the base year. For the first year of the prospective payment system, cost data shall be abstracted from the medicaid target amount computation (TAC) cost report. This cost report incorporates the adjustments made solely for the purpose of target amount determination in addition to adjustments made for final settlement. Supplemental cost reporting forms submitted by providers shall be used as necessary. Claims data shall be derived from claims submitted by participating providers for medicaid reimbursement. For the initial calculation of base year rates, claims from 1982 and 1983 facility fiscal years paid by December 31, 1984 shall be considered base year claim data. For subsequent calculation of rates by reference to a new base year, the latest available claims data for a two fiscal year period shall be used. Claims that are paid by December 31 of the year following the year in which the last fiscal year included in the data collection effort ends shall be considered as paid in the fiscal year when the service was rendered.

(b) Additional cost data supplied by participating providers shall be utilized to update cost data only as specified in this subchapter. For subsequent calculation of rates by reference to a new base year, providers will be given an opportunity to submit cost data similar in nature to that included in the TAC cost reports, excluding capital related costs.

(c) An inflation factor shall be based on the latest available actual (or estimated if actual is not

available) national index for acute care facilities prepared by Data Resources, Inc. This factor shall project the change in the cost of delivering inpatient hospital services from one year to the next. The inflation factor shall be published annually by the department. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-58 Classification of acute inpatient facilities. (a) For purposes of establishing prospective payment rates, acute inpatient facilities shall be classified into the following four mutually exclusive groups:

(1) Classification I - facilities averaging less than two hundred fifty medicaid discharges per year;
(2) Classification II - facilities averaging two hundred fifty medicaid discharges per year or more, which do not participate in approved intern and resident teaching programs;
(3) Classification III - facilities averaging two hundred fifty medicaid discharges per year or more, which participate in approved intern and resident teaching programs; and
(4) Classification IV - The freestanding rehabilitation hospital.

(b) If a facility changes classification in accordance with the definitions in subsection (a), rates established under this subchapter shall continue to apply until the department recalculates the rates using new base year data. Facility classification changes shall only be recognized at the time of such rebasing. A facility that adds an approved intern and resident teaching program, however, may seek rate reconsideration under section 17-1739-78(a)(3). [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-59 Service category designations. Services provided by acute inpatient facilities shall be classified into four mutually exclusive service categories:

(1) Maternity - an inpatient stay which results in a delivery with a maternity principal or secondary diagnosis code;

(2) Surgical - an inpatient stay with the following characteristics:
(A) The claim has not been classified as a maternity claim;
(B) The claim includes a surgical code that is considered to be an operating room procedure in the latest and most current version of the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM); and
(C) The claim includes either:
(i) A surgical date; or
(ii) An operating room charge.
(3) Psychiatric - an inpatient stay with a psychiatric primary diagnosis code and with no operating room charge; or
(4) Medical - an inpatient stay not classified into one of the above three service categories. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-60 Prospective payment rate. Prospective payment rates to inpatient hospitals providing acute care services in accordance with sections 17-1737-3 and 17-1737-4 shall be established in accordance with the methodology set forth in this subchapter. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-61 Preparation of data for calculation of base year prospective payment rates. (a) The department shall prepare data for the calculation of base year rates using the following general methodology.

(b) Base year claim charge data shall be prepared in order to establish charge ratios used in the payment calculation:
(1) Claim charge data for all Medicare cross-over claims shall be considered based on dates of discharge which correspond to each facility's fiscal year end;
(2) If more than one year of claim charge data is used, the charges reflected on the earlier year's claims data shall be inflated to the period covered by the most recent year's

claims data in accordance with section 17-1739-57(c);

(3) Claims shall be edited and properly classified;

(4) Claim charge data including charge amounts, days of care, and number of discharges, shall be classified into the four service categories identified in section 17-1739-59. Combined claims for the delivery of a normal newborn shall be counted as one discharge in the calculation process. Claims for newborns described in section 17-1739-66(a)(5) shall be classified into the appropriate service category;

(5) Claim charge data for surgical, maternity, and medical claims in classifications II and III facilities shall be segregated into routine, special care, and ancillary service charges. Nursery charges shall be included in the routine charges;

(6) Claim charge data shall be adjusted in the case of classifications II and III facilities to delete nonpsychiatric ancillary claim charges associated with claims in excess of $35,000; and

(7) Claim charge data shall be adjusted to delete ancillary charges for wait listed patients.

(c) Cost report data including costs, days, and discharges, shall be extracted from base year cost reports and shall be prepared in order to determine medicaid allowable inpatient facility costs:

(1) Costs of services excluded under section 17-1739-56 shall be deleted from costs for purposes of the prospective rate calculation. This process shall involve identifying items pertaining to the excluded services and subtracting these costs from the cost report data;

(2) Costs in excess of federal Medicare cost reimbursement limitations shall be deleted from costs for purposes of the prospective rate calculation. Costs which are not otherwise specifically addressed in this subchapter shall be included in a base year if they comply with HCFA publication number HIM 15 standards. Capital costs associated with the re-valuation of assets for any reason or due to a change in ownership,

operator, or leaseholder where such re-valuation occurred after July 18, 1984 shall be identified and excluded. Costs in excess of charges shall not be deleted from costs for the purpose of the prospective rate calculation;

(3) Allowable medicaid inpatient facility costs shall be determined separately for routine and ancillary costs. Nursery costs shall be combined with other routine costs and reclassified into the routine service component;

(4) The medicaid inpatient portion of malpractice costs shall be determined by multiplying the ratio of medicaid inpatient costs to total costs by the facility's total malpractice costs. This amount shall be added to allowable medicaid inpatient facility costs;

(5) To recognize cost differences due to varying fiscal year ends and annual inflationary increases, allowable medicaid inpatient facility costs shall be standardized and inflated as described in section 17-1739-68;

(6) Capital, medical education, and for proprietary facilities, return on equity and gross excise tax amounts shall be deleted from allowable medicaid inpatient facility costs and shall be reimbursed in accordance with section 17-1739-65;

(7) Except as provided in section 17-1739-59, services provided to patients during an inpatient stay but billed by a provider other than the inpatient facility shall be added to allowable medicaid inpatient facility costs. To obtain the estimated amount, the department shall survey facilities and accept reasonable estimates of such services; and

(8) In computing the nonpsychiatric ancillary per discharge rates, the total ancillary costs and discharges associated with nonpsychiatric outlier claims and ancillary costs associated with wait listed patients shall be deleted from allowable medicaid inpatient facility costs and discharges based on the claim charge ratios identified in subsection (b) above. Routine costs and days related to the outlier claims shall be included in inpatient costs and days extracted from the cost

reports and used in computation of the prospective payment rates. Routine costs and days related to wait listed patients shall not be extracted from the cost reports and shall be excluded from the computation of the inpatient rates. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-62 Calculation of base prospective rates for psychiatric services. (a) A base per diem rate for acute psychiatric inpatient services shall be established for all inpatient facilities using the following general methodology:

(1) Deduct the capital related costs allocated to psychiatric services on the base year cost report;

(2) Establish facility-specific ratios from claim charge data for psychiatric routine, special care, and ancillary charges and days to total routine, special care, and ancillary charges and days;

(3) Multiply the ratios in paragraph (2) by total medicaid inpatient costs excluding capital related cost, and days for routine, special care, and ancillary services to achieve total psychiatric routine, special care, and ancillary medicaid inpatient costs and days as derived from the cost report; and

(4) Total the resulting psychiatric costs and days for routine, special care, and ancillary services and achieve a facility-specific average medicaid psychiatric cost per day by dividing total psychiatric medicaid inpatient costs by total psychiatric inpatient medicaid days.

(b) A psychiatric per diem rate ceiling which applies to all facilities statewide shall be calculated in the following manner:

(1) Total the costs, excluding capital related costs, and days for all psychiatric services for all facilities, as identified in subsection (a);

(2) Divide the total psychiatric inpatient costs calculated in paragraph (1) by total psychiatric inpatient days; and

(3) Multiply the result of paragraph (2) by the

statewide psychiatric ceiling factor (one hundred fifteen per cent) published annually by the department. This result shall be the statewide base year per diem rate ceiling for psychiatric services.

(c) The prospective payment rate for psychiatric services for all facilities shall equal the lesser of either the facility-specific per diem rate or the per diem rate ceiling for inpatient psychiatric services. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-63 Calculation of base year prospective rates for classification I - nonpsychiatric services. (a) A base per diem rate for nonpsychiatric services for classification I facilities shall be established using the following general methodology:

(1) Deduct the capital related costs allocated to non-psychiatric services on the base year cost report;

(2) Calculate nonpsychiatric inpatient medicaid facility costs and days for all facilities in classification I by subtracting the facility's psychiatric costs and days for routine, special care, and ancillary services as specified in section 17-1739-62 from the facility's total allowable medicaid inpatient costs and days for routine, special care, and ancillary services as derived from the cost report and as calculated in section 17-1739-61; and

(3) Total the resulting costs, excluding capital related costs, and days for routine, special care, and ancillary services and achieve a facility-specific medicaid inpatient nonpsychiatric cost per day by dividing total nonpsychiatric medicaid costs by total nonpsychiatric inpatient medicaid days.

(b) The classification I per diem rate ceiling for nonpsychiatric services shall be calculated as follows:

(1) Total the costs, excluding capital related costs, and days for all nonpsychiatric services for all facilities in classification I, as identified in subsection (a);

(2) Divide total nonpsychiatric inpatient costs calculated in paragraph (1) by total

nonpsychiatric inpatient days for all facilities in classification I; and

(3) Multiply the result of paragraph (2) by the nonpsychiatric classification I ceiling factor (one hundred twenty per cent) published annually by the department. This result shall be the classification I per diem rate ceiling for nonpsychiatric facilities.

(c) The prospective payment rate for classification I facilities shall equal the lesser of either the facility-specific per diem rates or the classification I per diem rate ceiling for nonpsychiatric inpatient services.

[Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-64 Calculation of base prospective rates for classifications II and III - nonpsychiatric services. (a) The facility-specific prospective payment base rates for nonpsychiatric services rendered in facilities in classifications II and III shall be comprised of two separately established rate components, one per diem rate for routine services and one per discharge rate for ancillary services.

(b) The facility-specific base routine per diem and per discharge ancillary rate for nonpsychiatric services for each service category (maternity, surgical, and medical) shall be established using the following general methodology:

(1) Deduct the capital related costs allocated to nonpsychiatric services and ancillaries on the base year cost report;

(2) Determine separately for each service category the ratio of nonpsychiatric claim charges, days, and discharges to total claim charges, days, and discharges associated with routine, special care, and ancillary components;

(3) Multiply the ratios determined in paragraph (2) by total medicaid inpatient days, discharges and costs, excluding capital related costs;

(4) Determine the routine per diem costs for each service category by dividing the sum of routine and special care costs, excluding capital related costs, by the sum of routine

and special care days as derived from the cost report; and

(5) Determine the facility ancillary cost per discharge for each service category by dividing the ancillary service costs, excluding capital related costs, by the discharges as derived from the cost report.

(c) The base year per diem rate component ceiling shall be calculated for each nonpsychiatric service category for all facilities in classifications II and III as follows:

(1) For all facilities within a classification, total for each service category the routine costs, excluding capital related costs, and days identified in subsection (b);

(2) Divide total costs calculated in paragraph (1) for each service category by total patient days;

(3) Multiply the result of paragraph (2) for each facility classification by the nonpsychiatric classification II and III ceiling factor (one hundred twenty per cent) published annually by the department; and

(4) The result shall be the per diem rate component ceiling for nonpsychiatric services for each service category within each facility classification.

(d) A facility's prospective payment rate component for routine services for each nonpsychiatric service category shall equal the lesser of either the facility-specific base rate component or the per diem rate ceiling for the appropriate facility classification.

(e) The ancillary services per discharge rate component ceiling shall be established separately for each service category in the following manner:

(1) For all facilities within a classification, total the ancillary costs, excluding capital related costs, and discharges within each nonpsychiatric service category;

(2) Divide the total costs calculated in paragraph (1) by total discharges for each service category;

(3) Multiply the result of paragraph (2) for each facility classification by the nonpsychiatric classification II and III ceiling factor (one hundred twenty per cent) published annually by the department; and

(4) The result shall be the ancillary rate component ceiling for nonpsychiatric services for each nonpsychiatric service category within each facility classification.

(f) A facility's prospective per discharge base payment rate component for ancillary services for each nonpsychiatric service category shall equal the lesser of either the facility-specific per discharge base rate or the per discharge rate ceiling for the appropriate facility classification. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-65 Addition of facility-specific factors. (a) A facility's payment rates as determined above shall be adjusted for facility-specific factors, including capital, medical education, disproportionate share, and for proprietary facilities, return on equity and gross excise tax. Adjustments shall be calculated using the following general methodology.

(b) The interim capital adjustments shall be determined according to the general procedures that are used to reimburse providers for capital costs under Medicare, except that capital related costs shall be reduced by ten per cent. At the option of the department, the following procedure may be utilized:

(1) Each facility shall identify its capital related costs associated with providing acute care services. If a facility provides both acute and distinct part long term care services, then only the capital related costs associated with acute care shall be identified;

(2) Each facility shall submit an estimate of its allowable capital related costs and projected medicaid utilization for each PPS rate year. The projected medicaid utilization shall be based upon the ratio of medicaid patient days to total patient days;

(3) The department shall review the estimates for reasonableness and determine an amount of projected allowable capital related costs for each facility;

(4) For FY June 30, 1988, the projected allowable capital related costs shall be reduced by seven per cent. For all subsequent PPS fiscal years, the projected amount shall be reduced by ten per cent;

(5) After the appropriate reduction, the projected allowable capital related costs shall be divided by twelve;

(6) The product of the foregoing computation shall, at the department's option, be multiplied either by the facility's projected medicaid utilization rate or by the facility's actual medicaid utilization (based upon the ratio of medicaid patient days to total patient days) reflected in the most recently filed cost report; and

(7) The net result shall constitute the interim capital component of the facility's PPS rate, which shall be paid on a monthly basis throughout the fiscal year.

(c) The final capital adjustment shall be determined as follows:

(1) After the end of the fiscal year, the department shall adjust and settle the capital related costs of each facility based upon information reflected in the finally settled cost reports that cover the fiscal year under review;

(2) Capital related costs shall follow the Medicare PPS capital pass through methodology in 42 C.F.R. Part 413, Subpart G, as of October 1, 1987 except the percentage reduction applied to actual costs shall be seven per cent for the fiscal year ending June 30, 1988, and ten per cent for every year thereafter; and

(3) A provider may appeal the department's final settlement of capital related costs in accordance with the procedural requirements of chapter 17-1736. The department may settle tentatively on the capital related costs.

(d) For proprietary facilities, a return on equity factor, which represents a hospital's percentage of return on equity received in the base year under Medicare cost reimbursement principles, and gross excise tax factor, which represents gross excise tax paid on receipts in the base year, shall be determined as follows:

(1) Divide the total allowed medicaid inpatient return on equity and gross excise tax amounts separately by allowed medicaid inpatient total costs; and

(2) The result shall be added to 1.00 to obtain the return on equity and gross excise tax adjustment factors, respectively.

(e) For facilities which participate in an approved teaching program, a medical education factor shall be determined as follows:

(1) Divide allowed medicaid inpatient medical education costs by total allowed medicaid inpatient total costs;

(2) The result shall be added to 1.00 to obtain the medical education adjustment factor; and

(3) For new providers, the medical education factor shall be determined as part of the rate reconsideration process as authorized in section 17-1739-78(a)(3).

(f) Disproportionate share providers shall receive the disproportionate share adjustment factor. (Refer to section 17-1739-53, Definitions.)

(g) The facility-specific adjustment factors for return on equity, gross excise tax, disproportionate share, and medical education shall be multiplied by the facility's base prospective per diem and per discharge rates. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-66 Final prospective payment calculation. (a) Based on the prospective payment rates as adjusted in section 17-1739-65, and inflated in section 17-1739-68, a facility's payment for each inpatient stay in each classification shall be calculated as follows:

(1) For psychiatric discharges, multiply the per diem rate for a psychiatric discharge by the number of days of the psychiatric inpatient stay. The result shall be the payment for a psychiatric discharge;

(2) For nonpsychiatric service discharges in classification I facilities, multiply the per diem rate for the discharge by the number of days of the inpatient stay. The result shall be the payment for a nonpsychiatric service discharge;

(3) For surgical, maternity, and medical service discharges in classification II and III facilities, calculate the prospective payment for each facility as follows:

(A) Multiply the per diem rate component for the appropriate nonpsychiatric inpatient service category by the number of days of care for each service category for the inpatient discharge;
(B) Add the ancillary rate per discharge for the appropriate service category; and
(C) The result shall be the payment for each nonpsychiatric service discharge.

(4) If a woman delivers a child, then payment for the mother and baby shall be made separately. A per diem payment shall be made separately for care delivered to a normal newborn based on the costs and days associated with nursery care; and

(5) The following situations shall not be considered as constituting care that is delivered to a normal newborn, and shall be reimbursed as indicated:
(A) If it is medically necessary for the baby to remain in the hospital more than six days following birth (including the birthday), then the payment shall be determined separately based on the same criteria as any other discharge;
(B) If the claim form for services delivered to the newborn indicates an intensive care unit revenue code, then the payment for a medical case shall be made; or
(C) If both of the following requirements are met:
(i) The claim form reflects information that would result in the claim being characterized as a surgical case under section 17-1739-59(2); and
(ii) The newborn remains in the hospital for more than three days; then the payment for a surgical case shall be made.

(b) Payment shall be made under the prospective payment rate based on the date of discharge, except as provided in sections 17-1739-55(g) and 17-1739-71.

(c) Capital related costs shall be reimbursed as defined in section 17-1739-65(b).

[Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-67 Special prospective payment rate considerations. (a) For a facility with insufficient observations (less than five claims) in a given service category, the prospective payment rate shall be calculated using the weighted average for the applicable service category for the facility's classification.

(b) Prospective payment rates for classification IV, the freestanding rehabilitation hospital, shall be calculated in the following manner:

(1) Facility-specific claim charge data shall be prepared in accordance with section 17-1739-61;

(2) A facility-specific per diem base rate for psychiatric services shall be calculated in accordance with section 17-1739-62;

(3) A facility-specific per diem base rate for nonpsychiatric services shall be calculated by dividing total nonpsychiatric costs, excluding capital related costs for the hospital by nonpsychiatric medicaid inpatient days; and

(4) The facility-specific factors shall be computed or reimbursed as defined in section 17-1739-65. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-68 Adjustment to base year costs for inflation. (a) Cost increases due to varying fiscal year ends and inflation shall be recognized for purposes of establishing prospective payment rates in accordance with the following general methodology.

(b) Base year facility-specific costs shall be standardized to remove the effects caused by varying fiscal year ends of the facility. This shall be accomplished by dividing the inflation factor for the base year, as determined in accordance with section 17-1739-57 by twelve and multiplying this result by the number of months between the hospital's base year fiscal year end and June 30 of each year. This result shall be added to 1.00 to yield an inflation adjustment or which shall then be multiplied by the facility-specific costs.

(c) Cost increases due to inflation which occurred from the base year shall utilize the inflation factor specified in section 17-1739-57(c):

(1) For years during which the department does not recalculate the rates by reference to a new base year, cost increases due to inflation for state fiscal years 1987 and beyond shall be recognized by multiplying the prospective payment rate (excluding rate reconsideration relief) in effect on June 30 of the fiscal year by one plus the inflation factor for the following fiscal year. To insure the prospective nature of the PPS, the inflation factor shall not be retroactively adjusted nor modified except as noted below;

(2) For each year in which the department does recalculate the rates by reference to a new base year, cost increases due to inflation shall be recognized by multiplying the base year rates by one plus the inflation factor for each subsequent year, using the most current and accurate inflation data then available from Data Resources, Inc. (DRI). To insure the prospective nature of the PPS, that data shall not be retroactively adjusted nor modified; and

(3) For years in which the department does not recalculate the rates by reference to a new base year and in which the inflation factor for the prior year was reduced pursuant to subsection (d), then the average rates for the prior fiscal year shall be deemed to be the rates in effect on June 30.

(d) Absent circumstances beyond the control of the department, before the expiration of six months in each fiscal year the department shall determine whether the aggregate amount of reimbursement for that state fiscal year is projected to exceed the amount that would be paid for the same services under Medicare principles of reimbursement. In making that determination, the department shall exclude sums paid pursuant to section 17-1739-77(c) or any exception to or exemption from the inpatient operating cost limits as defined pursuant to 42 C.F.R. Part 413. In making its determination, the department shall use the most current information available, including the most recent cost reports filed by the facilities. If the projected aggregate amount of reimbursement is reasonably anticipated to exceed the amount that would be paid under Medicare principles of reimbursement, then the department shall reduce the inflation factor

used to calculate the rates for the remainder of the fiscal year so that the aggregate payments for the entire fiscal year (excluding the disproportionate share adjustments) are reasonably projected to be no more than that which would be paid under Medicare principles of reimbursement. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-69 Treatment of new facilities. (a) Rates for new providers shall be calculated by a separate method. A new provider shall receive the statewide weighted average payment rates for its classification times the following new provider adjustment factor:

(1) First Operating Year - one hundred fifty per cent;
(2) Second Operating Year - one hundred forty per cent;
(3) Third Operating Year - one hundred thirty per cent; and
(4) Fourth Operating Year and thereafter one hundred twenty five per cent;
(5) If a facility's operating year does not coincide with the PPS fiscal year, then the new provider's rates shall be prorated based on the PPS fiscal year. For example, a new provider that begins its first operating year on January 1 would receive one hundred forty-five per cent of the statewide weighted average payment rates for its classification for the entire PPS fiscal year that begins on the immediately following July 1.

(b) Capital related costs shall be reimbursed as defined in section 17-1739-65(b) and (c).

(c) For new providers that are proprietary facilities, the PPS rates shall also be adjusted by return on equity and gross excise tax factors. Those factors shall be based on projected costs and receipts and calculated as defined in section 17-1739-65(d).

(d) A new provider may seek rate reconsideration under section 17-1739-78(a)(3) if it adds an approved intern and resident teaching program. A new provider is also eligible for the disproportionate share adjustment if it meets the qualifications defined in this subchapter.

(e) A new provider shall have its PPS rates determined under this section until it no longer meets

the definition of a new provider. Thereafter, its PPS rates shall be based on its base year cost report like all other providers. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-70 Payment for transfers. (a) A hospital inpatient shall be considered "transferred" when the patient has been moved from one acute inpatient facility to another acute inpatient facility.

(b) A hospital which receives a transfer and subsequently discharges that individual shall be considered the discharging hospital. All other hospitals which admitted and subsequently transferred the patient during a single spell of illness shall be considered transferring hospitals.

(c) The service category into which the patient falls at the time of transfer or discharge shall be considered the appropriate service category for purposes of payment to that facility.

(d) If a classification I facility or the freestanding rehabilitation hospital transfers an inpatient to another classification I facility or the freestanding rehabilitation hospital, both facilities shall receive the per diem rates calculated in section 17-1739-66.

(e) If a classification I facility or the freestanding rehabilitation hospital transfers an inpatient to a classification II or III facility, the classification I facility shall receive the per diem rate calculated in section 17-1739-66, and the classification II or III facility shall receive the full per diem and ancillary reimbursement rate to which it is entitled under section 17-1739-66.

(f) If a classification II or III facility transfers an inpatient to another acute inpatient facility, payment shall be as follows:

(1) In nonpsychiatric cases where medical necessity requires that the patient remain in the transferring hospital three or more days or that the patient be cared for in the intensive care or coronary care units, the transferring classification II or III facility shall receive the full per diem rate for routine care and the full ancillary discharge rate for the appropriate service category, as calculated in accordance with section 17-1739-66;

(2) For nonpsychiatric cases of less than three days and not involving intensive care, payment to a transferring classification II or III facility shall be the facility-specific per diem rate for routine care and thirty per cent of the ancillary discharge rate for the appropriate service category, as calculated in accordance with section 17-1739-66;

(3) For nonpsychiatric services, payment to a discharging classification II or III facility shall be the full prospective payment rates calculated in section 17-1739-66;

(4) For nonpsychiatric services, payment to a discharging classification I facility or the freestanding rehabilitation facility shall be determined by multiplying the number of days of stay in the discharging facility by the per diem calculated in section 17-1739-66; and

(5) For psychiatric services, payment to any transferring or discharging facility shall be determined by multiplying the number of days of stay by the per diem calculated in section 17-1739-66.

(g) Transfers shall be subject to utilization review, and the department or its utilization review agent may deny full or partial payment to the transferring facility if it is determined that the transferring facility was able to provide all required care or that a patient was held three days or more or placed in intensive care when it was not medically necessary.

(h) For the purpose of determining capital related costs associated with transfers, all days and charges associated with services rendered by each facility to the transferred patient shall be included in that facility's computation. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-71 Payment for readmission. (a) Readmissions to the same facility within twenty four hours of discharge for the same spell of illness and for the same general diagnosis as the original admission shall be considered to be the same admission and shall be billed as a single stay. The department may deny full or partial payment for the original

inpatient stay or the subsequent readmission if it is determined that the facility could have provided all required services during the original inpatient stay. This section shall not apply in cases where a patient leaves the hospital against medical advice.

(b) Readmission to the same facility within thirty days of a previous discharge for a similar diagnosis shall be subject to utilization review. The department may deny full or partial payment for the original stay or the subsequent readmission if it is determined that the facility could have provided all required services during the original stay. This section shall not apply in cases where a patient leaves the hospital against medical advice. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-72 Payment for nonpsychiatric cases which exceed $35,000. If charges for nonpsychiatric services rendered to a patient during an inpatient stay are in excess of $35,000, billing and payment for this stay shall be as follows:

(1) For classification I facilities and the freestanding rehabilitation hospital, payment shall be made at applicable per diem rates for the full inpatient stay;

(2) For classification II and III facilities:

(A) An initial interim bill shall be submitted covering the period from the admission date through the date the charge for the case reaches $35,000. Payment for this interim bill shall be the classification per diem rate for the service category multiplied by the number of days covered by the bill plus the full appropriate ancillary rate as calculated in section 17-1739-68; and

(B) Sixty days after a patient reaches outlier status, monthly thereafter, and upon discharge, a facility shall bill the department for charges in excess of the outlier threshold. The facility shall also document to the department's reasonable satisfaction the medical necessity for the days of care and services rendered. The department shall pay such bills that are appropriately documented and properly within the scope

of the acute care medicaid program no less than quarterly. The department shall pay for the full per diem and eighty per cent of the ancillary charges, excluding amounts included in computing the outlier threshold; and

(3) For the purpose of determining capital related costs associated with outlier cases, the full amount of charges shall be included in the facility's computation.

[Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-73 Wait listed reimbursements. (a) Payments for wait listed patients shall reflect the level of care required by the patient. The facility shall receive a routine per diem for each day that a wait listed patient remains in the acute care part of the facility. Room and board wait listed rates are to be determined based upon the statewide weighted average costs of providing either SNF or ICF services by distinct part facilities per the medicaid long-term care prospective payment rate calculations with the following exceptions:

(1) The wait listed rates cannot exceed the facility's own distinct part SNF or ICF prospective payment rates;

(2) A facility with a distinct part SNF, but no ICF, would have an ICF wait listed rate based on the statewide weighted average but not to exceed the facility's distinct SNF prospective payment rate; and

(3) In no case will any relief granted under rate reconsideration be used to adjust the wait listed rates.

(b) Wait listed rates shall be annually adjusted by the same inflation factors as the long-term care PPS rates.

(c) The rate for wait listed long-term care patients in acute care beds does not include ancillary services except for medical supplies and maintenance therapy. These excluded ancillary services must therefore be billed separately. Reimbursements will be consistent with the ancillary rates paid to long term care facilities. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-74 Payment for services rendered to patients with other health insurance. medicaid is a secondary payor. In no case shall medicaid pay a sum, when considered in conjunction with payments from all other sources (including the patient's cost share and Medicare), that exceeds the amount that would have been paid if no other source of reimbursement existed. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-75 Limitations on acute care facility payment. (a) Calculation of the prospective payment rate shall not be affected by a public provider's imposition of nominal charges in accordance with federal regulations. However, for providers whose charges are less than costs on the most recently filed cost report and who do not qualify as a nominal charge provider, the prospective rate shall be reduced during the interim until the applicable cost report is filed and a settlement adjustment is made. The interim reduction shall be in proportion to the ratio of costs to charges on the most recent filed cost report. Updated data and charge structures may be provided to the department's fiscal intermediary if the provider believes that its rate structure has changed significantly since the most recent filed cost report, but the department will be responsible for approving the final interim rate reduction necessary to approximate final settlement as closely as possible.

(b) Payment for out-of-state acute care facility services shall be the medicaid rate applicable in the facility's state. If an out of state medicaid rate is not available, the weighted average Hawaii medicaid rate applicable to services provided in comparable Hawaii facilities shall be used.

(c) The department or its utilization review agent may deny full or partial payment if it is determined that the admission or transfer was not medically necessary or the diagnosis or procedure code was not correctly assigned, or the patient was retained in the facility longer than necessary. The department shall recover amounts due using the most expedient methods possible which shall include but not be limited to offsetting amounts against current payments due providers. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-76 Adjustments for costs under appeal. A change in a facility's base year costs due to appeals to the base year cost report that occur subsequent to the effective date of these rules shall not result in changes to the rate ceilings for the classification group until the next recalculation of rates. The facility-specific prospective payment rate calculated under section 17-1739-66 shall be adjusted to reflect the appeal decision. Base year costs shall be adjusted to reflect the appeal decision, and the facility-specific prospective rate shall be recalculated, effective the first day of the rate year, based on the adjusted base year costs, as long as the rate ceilings are not exceeded. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-77 Future redetermination of prospective payment rates. (a) In future years, prospective payment rates for acute care facilities shall be established by trending forward the base year prospective payment rates by adjusting estimated to actuals and applying the projected inflation factor, as defined in section 17-1739-57, for the prospective payment year at the start of each fiscal year.

(b) Reimbursement for capital related costs shall be computed annually as defined in section 17-1739-65(b).

(c) The department shall recalculate the prospective payment rates periodically by reference to a new base year. This recalculation shall be performed at least once every five years, except under extraordinary circumstances. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-78 Requests for rate reconsideration. (a) Acute care providers shall have the right to request a rate reconsideration if one of the following conditions has occurred since the base year:

(1) Extraordinary circumstances including but not limited to acts of God, changes in life and safety code requirements, changes in licensure law, rules or regulations, significant changes in case mix or the nature of service, or addition of new services occurring subsequent to the base year. Mere

inflation of costs, absent extraordinary circumstances, shall not be a ground for rate reconsideration;

(2) Reduction in medicaid average length of stay within a facility which produced a decrease in the average cost per discharge but an increase in the average cost per day. This paragraph shall not include reductions in average length of stay resulting from a change in case mix. The rate reconsideration relief provided under this section shall be the lesser of actual growth in the cost per day since the base year or seventy-five per cent of the reduction in the average cost per discharge (inflated) since the base year divided by the current average length of stay. In no case shall the add-on exceed the actual ancillary and room and board costs of the facility; and

(3) The addition of an approved intern and resident teaching program. This is the only circumstance that is eligible for a rate reconsideration request by a new provider.

(b) A provider may also obtain a rate reconsideration if it provides an atypically high percentage of special care, determined as follows. In order to obtain the relief, the provider must meet each of the tests and follow each of the procedures defined below:

(1) One or more of the facility's per diem rates is affected by the ceiling in its classification for that type of service;

(2) The percentage of the facility's base year medicaid special care days over total base year medicaid days (excluding days that are reported in the nursery cost center on the cost report) is greater than one hundred fifty per cent of the same average for all other facilities in its classification. The data to perform the comparison shall be obtained from the base year medicaid cost reports;

(3) The facility's average per diem costs for both general inpatient routine service and special care, excluding capital related costs and medical education costs, are no greater than one hundred twenty per cent of the weighted average for all other facilities in

the same classification. The data to perform the comparison shall be obtained from the base year medicaid cost reports;

(4) The provider must analyze its base year costs and vary its special care percentage to determine its break-even point. This analysis shall be performed for each PPS rate that was affected by a component ceiling;

(5) The provider must compute its special care percentage based upon the most recent information available;

(6) The provider must certify to the department in conjunction with its rate reconsideration request that, based upon its most recently filed cost report, the percentage defined in section 17-1739-78(b)(2) continues to exceed one hundred fifty per cent of the average for all other facilities in its classification during the base year. The certification shall be based upon a cost report classification method that is consistent with the method that the facility used in the base year medicaid cost report; and

(7) The provider must submit the results of all of the foregoing analyses and calculations, along with its certification, to the department as part of its rate reconsideration request. For each rate category in which the most recent special care percentage exceeds the break-even point, the provider shall have the applicable PPS rate increased by the amount that it was reduced due to the application of the component ceilings. For each rate category in which the most recent special care percentage is equal to or less than the break-even point, the provider shall receive no increase in its PPS rates.

(c) Requests for reconsideration shall be submitted in writing to the department and shall set forth the reasons for the requests. Each request shall be accompanied by sufficient documentation to enable the department to act upon the requests. Documentation shall include the data necessary to demonstrate that the circumstances for which reconsideration is requested meet the requirements noted above. Documentation shall include:

(1) A presentation of data to demonstrate reasons for the hospital's request for rate reconsideration; and

(2) If the reconsideration request is based on changes in patient mix, then the facility must document the change using diagnosis related group case-mix index or other well-established case-mix measures, accompanied by a showing of cost implications.

(d) A request for reconsideration shall be submitted within sixty days after the prospective rate is provided to the facility by the department or at other times throughout the year if the department determines that extraordinary circumstances occurred. The addition of an approved intern and resident teaching program shall be one example of that type of extraordinary circumstance that justifies a mid-year rate reconsideration request.

(e) The provider shall be notified of the department's discretionary decision in writing within a reasonable time after receipt of the written request.

(f) Pending the department's discretionary decision on a request for rate reconsideration, the facility shall be paid the prospective payment rate initially determined by the department. If the reconsideration request is granted, the resultant new prospective payment rate shall be effective no earlier than the first date of the prospective rate year.

(g) A provider may appeal the department's decision on the rate reconsideration. The appeal shall be filed in accordance with the requirements of chapter 17-1736.

(h) Rate reconsiderations granted under this section shall be effective for the remainder of the prospective rate year. If the facility believes its experience justifies continuation of the rate in subsequent rate years, it shall submit information to update the documentation specified in subsection (c) within sixty days of notice of the facility's rate for each subsequent rate year. The department shall review the documentation and notify the facility of its determination as described in subsection (e). The department may, at its discretion, grant a rate adjustment which is automatically renewable until the base year is recalculated. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-79 Cost report requirements. (a) All participating acute care facilities shall maintain an accounting system which identifies costs in a manner that conforms to generally accepted accounting principles.

(b) Participating facilities shall submit the following on an annual basis no later than ninety days after the close of each facility's fiscal year:

(1) Uniform cost report;
(2) Working trial balance;
(3) Provider cost report questionnaire;
(4) Audited financial statements if available; and
(5) Disclosure of appeal items included in the cost report.

(c) Payment for services shall be temporarily reduced by at least twenty per cent if the cost report is not received within one hundred twenty days, and one hundred per cent if the cost report is not received within one hundred fifty days. A thirty day maximum extension will be granted upon written request for good cause as provided in Medicare guidelines.

(d) Each provider shall keep financial and statistical records of the cost reporting year for at least five years after submitting the cost report to authorized state or federal representatives. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-80 Audit requirements. (a) All costs reports shall be analyzed within six months after receipt to verify that each acute care provider has complied with medicaid cost reporting requirements.

(b) On-site audits of cost reports, including financial and statistical records of a sample of participating facilities in each facility classification, shall be conducted annually.

(c) Upon conclusion of each on-site audit, a report of the audit findings shall be retained by the medicaid agency for a period of not less than three years following the date of submission of the report.

(d) Facilities shall have the right to appeal audit findings. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-81 Effective date of amendments to subchapter 3. Unless otherwise stated, amendments to this subchapter shall be effective concurrent with the effective date of federal approval to a corresponding amendment to the Hawaii medicaid State Plan for inpatient hospital reimbursement. [Eff 11/13/95] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)